This report is	s required by law (42 USC 1395g; 42 CFR 413.20(b)). Fai	lure to report can res	ult in all interim	FORM APPROVED
payments made	since the beginning of the cost reporting period being	deemed overpayments ((42 USC 1395g).	OMB NO. 0938-0050
				EXPIRES 05-31-2019
HOSPITAL AND H	HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION F SUMMARY	Provider CCN: 15-0010	Peri od: From 07/01/2017 To 06/30/2018	
PART I - COST	REPORT STATUS			
Provi der	1. [X] Electronically filed cost report		Date: 11/26/2	018 Time: 3:02 pm
use only	2. [] Manually submitted cost report			
	3.[0] If this is an amended report enter the number 4.[F] Medicare Utilization. Enter "F" for full or "L	of times the provider _" for low.	resubmitted this co	ost report
Contractor use only	5. [1] Cost Report Status (1) As Submitted 7. Contractor No. (2) Settled without Audit (3) Settled with Audit (4) Reopened (5) Amended 6. Date Received: 7. Contractor No. 8. [N] Initial Report for 9. [N] Final Report for 1. Settled with Audit 1. Settled with	11 or this Provider CCN 12		
DADT II CEDT	FLETCATION			

MISREPRESENTATION OR FALSIFICATION OF ANY INFORMATION CONTAINED IN THIS COST REPORT MAY BE PUNISHABLE BY CRIMINAL. CIVIL AND ADMINISTRATIVE ACTION, FINE AND/OR IMPRISONMENT UNDER FEDERAL LAW. FURTHERMORE, IF SERVICES IDENTIFIED IN THIS REPORT WERE PROVIDED OR PROCURED THROUGH THE PAYMENT DIRECTLY OR INDIRECTLY OF A KICKBACK OR WERE OTHERWISE ILLEGAL, CRIMINAL, CIVIL AND ADMINISTRATIVE ACTION, FINES AND/OR IMPRISONMENT MAY RESULT.

CERTIFICATION BY CHIEF FINANCIAL OFFICER OR ADMINISTRATOR OF PROVIDER(S)

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by ST. JOSEPH HOSPITAL & HEALTH CENTER (15-0010) for the cost reporting period beginning 07/01/2017 and ending 06/30/2018 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

]I have read and agree with the above certification statement. I certify that I intend my electronic signature on this certification statement to be the legally binding equivalent of my original signature.

(Si gned)	
	Officer or Administrator of Provider(s)
	• ,
Title	
-	
Date	

			Title XVIII				
	Cost Center Description	Title V	Part A	Part B	HI T	Title XIX	
		1. 00	2. 00	3. 00	4. 00	5. 00	
	PART III - SETTLEMENT SUMMARY						
1.00	Hospi tal	0	166, 112	17, 147	0	0	1. 00
2.00	Subprovider - IPF	0	0	0		0	2. 00
3.00	Subprovider - IRF	0	2, 196	0		0	3. 00
5.00	Swing bed - SNF	0	0	0		0	5. 00
6.00	Swing bed - NF	0				0	6. 00
200.00	Total	0	168, 308	17, 147	0	0	200. 00

The above amounts represent "due to" or "due from" the applicable program for the element of the above complex indicated.

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0050. The time required to complete and review the information collection is estimated 673 hours per response, including the time to review instructions, search existing resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving the form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Report Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850. Please do not send applications, claims, payments, medical records or any documents containing sensitive information to the PRA Reports Clearance Office. Please note that any correspondence not pertaining to the information collection burden approved under the associated OMB control number listed on this form will not be reviewed, forwarded, or retained. If you have questions or concerns regarding where to submit your documents, please contact 1-800-MEDICARE. HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provider CCN: 15-0010 Peri od: Worksheet S-2 From 07/01/2017 Part I Date/Time Prepared: 06/30/2018 11/26/2018 12:03 pm 3.00 4.00 Hospital and Hospital Health Care Complex Address: Street: 1907 WEST SYCAMORE STREET 1.00 PO Box: 1.00 State: IN 2.00 City: KOKOMO Zip Code: 46901 County: HOWARD 2.00 Component Name CCN CBSA Provi der Date Payment System (P, Certi fi ed T, 0, or N) Number Number Type XVIII XIX 1.00 2.00 3.00 4.00 5.00 6.00 | 7.00 | 8.00 Hospital and Hospital-Based Component Identification: 3.00 ST. JOSEPH HOSPITAL & 150010 29020 07/01/1966 Ν Р 0 3.00 1 HEALTH CENTER Subprovider - IPF 4.00 4 00 5.00 Subprovider - IRF ST. JOSEPH ACUTE REHAB 15T010 29020 5 07/01/2002 Ν Ρ 0 5.00 6.00 Subprovider - (Other) 6.00 Swing Beds - SNF 7.00 7 00 8.00 Swing Beds - NF 8.00 9.00 Hospi tal -Based SNF 9.00 Hospi tal -Based NF 10.00 10.00 11.00 Hospi tal -Based OLTC 11.00 12.00 Hospi tal -Based HHA 12.00 Separately Certified ASC 13.00 13.00 Hospi tal -Based Hospi ce 14.00 14.00 Hospital-Based Health Clinic - RHC 15.00 15 00 Hospital -Based Health Clinic - FQHC 16.00 17.00 Hospital-Based (CMHC) I 17.00 Renal Dialysis 18.00 18.00 19.00 Other 19.00 From: 2.00 1.00 20.00 Cost Reporting Period (mm/dd/yyyy) 07/01/2017 06/30/2018 20.00 21.00 Type of Control (see instructions) 21.00 1 Inpatient PPS Information Does this facility qualify and is it currently receiving payments for disproportionate 22.00 Υ N 22.00 share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.106(c)(2)(Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no. Did this hospital receive interim uncompensated care payments for this cost reporting Υ Υ 22.01 period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) 22.02 Is this a newly merged hospital that requires final uncompensated care payments to be Ν Ν 22.02 determined at cost report settlement? (see instructions) Enter in column 1, "Y" for yes or "N" for no, for the portion of the cost reporting period prior to October 1. Enter "Y" for yes or "N" for no, for the portion of the cost reporting period on in column 2. or after October 1 22.03 Did this hospital receive a geographic reclassification from urban to rural as a result N N 22 03 of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no. Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 23.00 3 Ν 23 00 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method enter "Y" "N" fo<u>r no</u>. used in the prior cost reporting period? In column 2 for yes or In-State Out-of Medi cai d Other In-State Out-of Medi cai d Medi cai d State State HMO days Medi cai d paid days el i gi bl e Medi cai d Medi cai d days pai d days unpai d el i gi bl e days unpai d 1.00 2.00 3. 00 4.00 5.00 6.00 24.00 If this provider is an IPPS hospital, enter the 32 433 6 4, 607 24. 00 in-state Medicaid paid days in column 1, in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid paid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6. 25.00 If this provider is an IRF, enter the in-state 0 15 0 0 107 25.00 Medicaid paid days in column 1, the in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5.

		. & HEALTH CENT			n Lie	u of For		
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DA	ATA	Provider CC	F	eriod: rom 07/01/ o 06/30/		Workshe Part I		
			T			Date/Ti 11/26/2	018 12	03 pm
				Urban/Rur 1.00	ai s	2.0		
26.00 Enter your standard geographic classification (not was cost reporting period. Enter "1" for urban or "2" for 27.00 Enter your standard geographic classification (not was constituted by the control of the contro	rural. age) sta	atus at the end	d of the cost		1			26. 00
reporting period. Enter in column 1, "1" for urban or enter the effective date of the geographic reclassifi 35.00 If this is a sole community hospital (SCH), enter the	cati on	in column 2.			0			35. 00
effect in the cost reporting period.				Begi nni r	ng:	Endi ı		
36.00 Enter applicable beginning and ending dates of SCH st	tatus. S	Subscript line	36 for number	1.00		2.0	00	36. 00
of periods in excess of one and enter subsequent date 37.00 If this is a Medicare dependent hospital (MDH), enter	es.	•			0			37. 00
is in effect in the cost reporting period. 37.01 Is this hospital a former MDH that is eligible for the accordance with FY 2016 OPPS final rule? Enter "Y" for	ne MDH t	transitional pa	ayment in	N				37. 01
instructions) 38.00 If line 37 is 1, enter the beginning and ending dates	,		·					38. 00
greater than 1, subscript this line for the number of enter subsequent dates.				V/N		V //	AI.	30.00
				Y/N 1. 00		Y/I 2. C		
39.00 Does this facility qualify for the inpatient hospital hospitals in accordance with 42 CFR §412.101(b)(2)(i) for yes or "N" for no. Does the facility meet the mil with 42 CFR 412.101(b)(2)(i) or (ii)? Enter in column	or (ii eage re)? Enter in co equirements in	olumn 1 "Y" accordance	N		N		39. 00
instructions) 40.00 Is this hospital subject to the HAC program reduction "N" for no in column 1, for discharges prior to Octob no in column 2, for discharges on or after October 1.	per 1. E	Enter "Y" for y		N		N		40. 00
	(See 1	risti ucti oris)			V 1. 00	XVIII 2.00	XI X 3. 00	
Prospective Payment System (PPS)-Capital 45.00 Does this facility qualify and receive Capital paymen	nt for d	di sproporti onat	te share in acc	cordance	N	Υ	N	45. 00
with 42 CFR Section §412.320? (see instructions) 46.00 Is this facility eligible for additional payment exception for extraordinary circumstances pursuant to 42 CFR §412.348(f)? If yes, complete Wkst. L, Pt. III and Wkst. L-1, Pt. I through						N	N	46. 00
47.00 Is this a new hospital under 42 CFR §412.300(b) PPS c 48.00 Is the facility electing full federal capital payment							N N	47. 00 48. 00
Teaching Hospitals 56.00 Is this a hospital involved in training residents in	approve	ed GME programs	? Enter "Y" f	or yes	N			56. 00
or "N" for no. 57.00 If line 56 is yes, is this the first cost reporting posts. GME programs trained at this facility? Enter "Y" for is "Y" did residents start training in the first mont	yes or th of th	r "N" for no ir nis cost report	n column 1. If ting period? E	column 1 Enter "Y"				57. 00
for yes or "N" for no in column 2. If column 2 is "Y "N", complete Wkst. D, Parts III & IV and D-2, Pt. II	, if ap	opl i cabl e.						
58.00 If line 56 is yes, did this facility elect cost reimb defined in CMS Pub. 15-1, chapter 21, §2148? If yes,	complet	te Wkst. D-5.		is				58. 00
59.00 Are costs claimed on line 100 of Worksheet A? If yes	s, compl	ete WKST. D-2,	NAHE 413.85	Workshee		Pass-Th		59. 00
			Y/N	Line #		Qualifi Criteric		
60.00 Are you claiming nursing and allied health education	(NAHF)	costs for	1. 00 Y	2.00		3. C	00	60.00
any programs that meet the criteria under §413.85? (60.01 If line 60 is yes, complete columns 2 and 3 for each instructions)	(see ins	structions)	·	2	23. 00	1		60. 01
i noti doti ono)	Y/N	IME	Direct GME	IME		Di rect	GME	
44 00 001	1.00	2. 00	3. 00	4.00		5. C		(1.00
61.00 Did your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions) 61.01 Enter the average number of unweighted primary care FTEs from the hospital's 3 most recent cost reports	N				0.00		0.00	61. 00
ending and submitted before March 23, 2010. (see instructions) 61.02 Enter the current year total unweighted primary care FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of								61. 02
ACA). (see instructions) 61.03 Enter the base line FTE count for primary care and/or general surgery residents, which is used for determining compliance with the 75% test. (see instructions)								61. 03

Health Financial Systems ST. JOSEPH	HOSPI TAL	& HEALTH CENT		In Lie	eu of Form CMS-2	2552-10
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION D	ATA	Provider C	CN: 15-0010	Peri od: From 07/01/2017 To 06/30/2018		pared:
	Y/N	IME	Direct GME	IME	Direct GME	
	1. 00	2. 00	3. 00	4. 00	5. 00	
61.04 Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the current cost reporting period. (see instructions). 61.05 Enter the difference between the baseline primary and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (line 61.04 minus line 61.03). (see instructions) 61.06 Enter the amount of ACA §5503 award that is being used for cap relief and/or FTEs that are nonprimary						61. 04 61. 05
care or general surgery. (see instructions)			D 0 1			
	Pro	ogram Name	Program Cod	e Unweighted IME FTE Count	Unweighted Direct GME FTE Count	
		1. 00	2. 00	3. 00	4. 00	
61.10 Of the FTEs in line 61.05, specify each new program specialty, if any, and the number of FTE residents for each new program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count.				0. 00	J 0. 00	61. 10
61.20 Of the FTEs in line 61.05, specify each expanded program specialty, if any, and the number of FTE residents for each expanded program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count.	1			0.00	0.00	61. 20
					1. 00	
ACA Provisions Affecting the Health Resources and Se 62.00 Enter the number of FTE residents that your hospital				ried for which	0.00	62.00
your hospital received HRSA PCRE funding (see instru 62.01 Enter the number of FTE residents that rotated from during in this cost reporting period of HRSA THC pro	ıctions) a Teachi ogram. (s	ng Health Cen see instructio	ter (THC) int			62. 01
63.00 Has your facility trained residents in nonprovider s	ettings	during this c			N	63. 00
"Y" for yes or "N" for no in column 1. If yes, compl	ete iine	zs o4 tillough	Unwei ghted FTEs Nonprovi der Si te	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))	
Section 5504 of the ACA Base Year FTE Residents in N	lonnrovi o	der Settings	1.00	2.00	3.00	
period that begins on or after July 1, 2009 and before	ore June	30, 2010.				
64.00 Enter in column 1, if line 63 is yes, or your facili in the base year period, the number of unweighted no resident FTEs attributable to rotations occurring in settings. Enter in column 2 the number of unweighter resident FTEs that trained in your hospital. Enter if of (column 1 divided by (column 1 + column 2)). (see	r facility trained residents 0.00 0.00 0.000 ghted non-primary care rring in all nonprovider nweighted non-primary care Enter in column 3 the ratio					64.00
Program Name	Pro	ogram Code	Unwei ghted FTEs Nonprovi der Si te	FTEs in	Ratio (col. 3/ (col. 3 + col. 4))	
1.00		2. 00	3. 00	4. 00	5. 00	

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provider CCN: 15-0010 Peri od: Worksheet S-2 From 07/01/2017 Part I Date/Time Prepared: 06/30/2018 11/26/2018 12:03 pm Program Code Unwei ghted Unwei ghted Program Name Ratio (col. (col. 3 + col FTEs FTEs in Nonprovi der Hospi tal 4)) Si te 1.00 2.00 3.00 4.00 5.00 65.00 Enter in column 1, if line 63 is yes, or your facility 0. 00 0. 00 0.000000 65.00 trained residents in the base year period, the program name associated with primary care FTEs for each primary care program in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions) Unwei ghted Unwei ghted Ratio (col. 1/ FTEs FTEs in (col. 1 + col Nonprovi der Hospi tal 2)) Si te 1.00 2.00 3.00 Section 5504 of the ACA Current Year FTE Residents in Nonprovider Settings--Effective for cost reporting periods beginning on or after July 1, 2010 Enter in column 1 the number of unweighted non-primary care resident 0.00 0. 00 0.000000 66.00 FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions) Program Name Unwei ghted Ratio (col. 3/ Program Code Unwei ahted FTES FTEs in (col. 3 + col Nonprovi der Hospi tal 4)) Si te 1.00 2.00 3. 00 4.00 5.00 67.00 Enter in column 1, the program 0.000000 67.00 0.00 0.00 name associated with each of your primary care programs in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)) (see instructions) 1.00 2.00 3.00 Inpatient Psychiatric Facility PPS Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF subprovider? 70.00 Enter "Y" for yes or "N" for no. 71.00 If line 70 is yes: Column 1: Did the facility have an approved GME teaching program in the most O 71.00 recent cost report filed on or before November 15, 2004? Enter "Y" for yes or "N" for no. (see 42 CFR 412.424(d)(1)(iii)(c)) Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions) Inpatient Rehabilitation Facility PPS 75.00 Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF 75.00 subprovider? Enter "Y" for yes and "N" for no. If line 75 is yes: Column 1: Did the facility have an approved GME teaching program in the most Ν Ν 0 76.00 recent cost reporting period ending on or before November 15, 2004? Enter "Y" for yes or "N" for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)

Health Financial Systems ST. JOSEPH HOSPITAL	& HEALTH CENT	ER	In Lie	u of Form CMS-	2552-10	
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provi der CC	N: 15-0010	Peri od: From 07/01/2017 To 06/30/2018	Worksheet S-2 Part I Date/Time Pre 11/26/2018 12	pared:	
				1. 00	1	
Long Term Care Hospital PPS	L HAIII C				00.00	
80.00 Is this a long term care hospital (LTCH)? Enter "Y" for yes 81.00 Is this a LTCH co-located within another hospital for part c "Y" for yes and "N" for no. TEFRA Providers			g period? Enter	N N	80. 00 81. 00	
85.00 Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) 86.00 Did this facility establish a new Other subprovider (exclude §413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no.	on	N	85. 00 86. 00			
87.00 Is this hospital an extended neoplastic disease care hospital 1886(d)(1)(B)(vi)? Enter "Y" for yes or "N" for no.	ıl classified ι	under section		N	87. 00	
			V	XI X		
Title V and XIX Services			1. 00	2. 00		
90.00 Does this facility have title V and/or XIX inpatient hospital yes or "N" for no in the applicable column.	ıl services? Er	nter "Y" for	N	Y	90. 00	
91.00 Is this hospital reimbursed for title V and/or XIX through t full or in part? Enter "Y" for yes or "N" for no in the appl			N	N	91. 00	
92.00 Are title XIX NF patients occupying title XVIII SNF beds (du instructions) Enter "Y" for yes or "N" for no in the applica	ıal certificati			N	92. 00	
"Y" for yes or "N" for no in the applicable column.	3.00 Does this facility operate an ICF/IID facility for purposes of title V and XIX? Enter N					
applicable column.						
96.00 Does title V or XIX reduce operating cost? Enter "Y" for yes	6.00 Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the					
97.00 If line 96 is "Y", enter the reduction percentage in the app 98.00 Does title V or XIX follow Medicare (title XVIII) for the ir	28.00 Does title V or XIX follow Medicare (title XVIII) for the interns and residents post N stepdown adjustments on Wkst. B, Pt. I, col. 25? Enter "Y" for yes or "N" for no in					
98.01 Does title V or XIX follow Medicare (title XVIII) for the reC, Pt. I? Enter "Y" for yes or "N" for no in column 1 for title XIX.				Y	98. 01	
98.02 Does title V or XIX follow Medicare (title XVIII) for the cabed costs on Wkst. D-1, Pt. IV, line 89? Enter "Y" for yes of for title V, and in column 2 for title XIX.			N	Y	98. 02	
98.03 Does title V or XIX follow Medicare (title XVIII) for a crit reimbursed 101% of inpatient services cost? Enter "Y" for ye for title V, and in column 2 for title XIX.				N	98. 03	
98.04 Does title V or XIX follow Medicare (title XVIII) for a CAH outpatient services cost? Enter "Y" for yes or "N" for no in in column 2 for title XIX.			N	N	98. 04	
98.05 Does title V or XIX follow Medicare (title XVIII) and add ba Wkst. C, Pt. I, col. 4? Enter "Y" for yes or "N" for no in c column 2 for title XIX.				Y	98. 05	
98.06 Does title V or XIX follow Medicare (title XVIII) when cost Pts. I through IV? Enter "Y" for yes or "N" for no in column column 2 for title XIX.			N	Y	98. 06	
Rural Providers 105.00 Does this hospital qualify as a CAH?			N		105. 00	
106.00 ff this facility qualifies as a CAH, has it elected the all- for outpatient services? (see instructions)	inclusive meth	nod of paymen			106. 00	
107.00 If this facility qualifies as a CAH, is it eligible for cost training programs? Enter "Y" for yes or "N" for no in column yes, the GME elimination is not made on Wkst. B, Pt. I, col.	n 1. (see instr	ructions) If	t		107. 00	
reimbursed. If yes complete Wkst. D-2, Pt. II. 108.00 s this a rural hospital qualifying for an exception to the CFR Section §412.113(c). Enter "Y" for yes or "N" for no.	CRNA fee sched	dul e? See 42	N		108. 00	
JOHN SECTION 3412. 113(6). Litter 1 101 yes of W 101 HU.	Physi cal 1.00	Occupationa 2.00	Speech 3.00	Respiratory 4.00		
					100 0	

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Prov	TH CENTER ider CCN: 15-0010	Peri od:	Worksheet S	IS-2552- S-2
		From 07/01/2 To 06/30/2	2017 Part I	Prepared
		1. 00	2.00	
11.00 If this facility qualifies as a CAH, did it participate in the Fron Health Integration Project (FCHIP) demonstration for this cost repo "Y" for yes or "N" for no in column 1. If the response to column 1 integration prong of the FCHIP demo in which this CAH is participat Enter all that apply: "A" for Ambulance services; "B" for additiona for tele-health services.	rting period? Enter is Y, enter the ing in column 2.	N		111. (
			1.00 2.00 3.0	00
Miscellaneous Cost Reporting Information 115.00 Is this an all-inclusive rate provider? Enter "Y" for yes or "N" for is yes, enter the method used (A, B, or E only) in column 2. If col 3 either "93" percent for short term hospital or "98" percent for I psychiatric, rehabilitation and long term hospitals providers) base Pub. 15-1, chapter 22, §2208.1.	umn 2 is "E", enter ong term care (incl d on the definition	in column udes	N O	
16.00 Is this facility classified as a referral center? Enter "Y" for yes 117.00 Is this facility legally-required to carry malpractice insurance? E no.	nter "Y" for yes o		N Y	116. 0 117. 0
18.00 is the mal practice insurance a claims-made or occurrence policy? En claim-made. Enter 2 if the policy is occurrence.	ter 1 if the policy	/is	2	118. 0
joi ariii iiiaaci Erresi E rri tilo poliroy ro coodii ronoo.	Premi ums	Losses	Insurance	!
	1. 00	2.00	3.00	
18.01 List amounts of malpractice premiums and paid losses:	625, 7	722	0	0 118. 0
		1. 00	2.00	
18. 02 Are malpractice premiums and paid losses reported in a cost center Administrative and General? If yes, submit supporting schedule lis and amounts contained therein. 19. 00 DO NOT USE THIS LINE		N		118. (
20.00 s this a SCH or EACH that qualifies for the Outpatient Hold Harmle §3121 and applicable amendments? (see instructions) Enter in column "N" for no. Is this a rural hospital with < 100 beds that qualifies Hold Harmless provision in ACA §3121 and applicable amendments? (see Enter in column 2, "Y" for yes or "N" for no.	1, "Y" for yes or for the Outpatien		N	120. 0
21.00 Did this facility incur and report costs for high cost implantable	devices charged to	Y		121. (
patients? Enter "Y" for yes or "N" for no. 22.00 Does the cost report contain healthcare related taxes as defined in Act?Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y" the Worksheet A line number where these taxes are included.			5. 00	122. (
Transplant Center Information 25.00 Does this facility operate a transplant center? Enter "Y" for yes a	nd "N" for no lf	N		125. (
yes, enter certification date(s) (mm/dd/yyyy) below. 26.00 f this is a Medicare certified kidney transplant center, enter the				126.
in column 1 and termination date, if applicable, in column 2. 27.00 olf this is a Medicare certified heart transplant center, enter the	certification date			127.
in column 1 and termination date, if applicable, in column 2. 28.00 If this is a Medicare certified liver transplant center, enter the	certification date			128.
in column 1 and termination date, if applicable, in column 2. 29.00 If this is a Medicare certified lung transplant center, enter the c	ertification date i	n		129.
column 1 and termination date, if applicable, in column 2. 30.00 If this is a Medicare certified pancreas transplant center, enter t	he certification			130.
date in column 1 and termination date, if applicable, in column 2. 31.00 If this is a Medicare certified intestinal transplant center, enter	the certification			131. (
date in column 1 and termination date, if applicable, in column 2. 32.00 If this is a Medicare certified islet transplant center, enter the	certification date			132. (
in column 1 and termination date, if applicable, in column 2. 33.00 If this is a Medicare certified other transplant center, enter the	certification date			133. (
in column 1 and termination date, if applicable, in column 2. 34.00 If this is an organ procurement organization (0P0), enter the 0P0 n and termination date, if applicable, in column 2.	umber in column 1			134. (
All Providers	i = CMC Dul 45 1	,	450047	140
40.00 Are there any related organization or home office costs as defined chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, an		Y	15H046	140. (

Health Financial Systems ST. JOSEPH HOSPITAL & HEALTH CENTER In Lieu of Form CMS-2552-10 HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provi der CCN: 15-0010 Peri od: Worksheet S-2 From 07/01/2017 Part I 06/30/2018 Date/Time Prepared: 11/26/2018 12:03 pm 3.00 If this facility is part of a chain organization, enter on lines 141 through 143 the name and address of the home office and enter the home office contractor name and contractor number

Name: ST VINCENT HEALTH | Contractor's Name: WPS Contractor's Number: 08101 141 00 Name: ST VINCENT HEALTH 141 00 142.00 Street: 250 W 96TH STREET, SUITE 215 PO Box: 142.00 143.00 City: INDIANAPOLIS 46260 143. 00 State: Zip Code: 1.00 144.00 Are provider based physicians' costs included in Worksheet A? 144. 00 γ 1. 00 2.00 145.00|If costs for renal services are claimed on Wkst. A, line 74, are the costs for 145 00 inpatient services only? Enter "Y" for yes or "N" for no in column 1. If column 1 is no, does the dialysis facility include Medicare utilization for this cost reporting period? Enter "Y" for yes or "N" for no in column 2. 146.00 Has the cost allocation methodology changed from the previously filed cost report? 146.00 Ν Enter "Y" for yes or "N" for no in column 1. (See CMS Pub. 15-2, chapter 40, §4020) If yes, enter the approval date (mm/dd/yyyy) in column 2. 1.00 147.00 Was there a change in the statistical basis? Enter "Y" for yes or "N" for no. 148.00 Was there a change in the order of allocation? Enter "Y" for yes or "N" for no. 147. 00 Ν 148 00 N 149.00 Was there a change to the simplified cost finding method? Enter "Y" for yes or "N" for no N 149.00 Part A Part B Title V Title XIX 1.00 2.00 3.00 4.00 Does this facility contain a provider that qualifies for an exemption from the application of the lower of costs or charges? Enter "Y" for yes or "N" for no for each component for Part A and Part B. (See 42 CFR §413.13) 155.00 Hospi tal 155.00 Ν N 156.00 Subprovi der - IPF Ν Ν Ν Ν 156.00 157.00 Subprovi der - IRF 157 00 N Ν Ν N 158. 00 SUBPROVI DER 158. 00 159.00 SNF Ν Ν Ν 159. 00 Ν 160.00 HOME HEALTH AGENCY 160.00 Ν Ν Ν Ν 161.00 CMHC Ν Ν N 161. 00 1.00 Multicampus 165.00 s this hospital part of a Multicampus hospital that has one or more campuses in different CBSAs? N 165.00 Enter "Y" for yes or "N" for no. Name County State Zip Code CBSA FTE/Campus 0 1.00 2.00 3.00 4.00 5.00 166.00 If line 165 is yes, for each 0.00 166.00 campus enter the name in column O, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions) 1.00 Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act 167.00 s this provider a meaningful user under §1886(n)? Enter "Y" for yes or "N" for no. 167 00 168.00 of this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the d168. 00 reasonable cost incurred for the HIT assets (see instructions) 168.01 If this provider is a CAH and is not a meaningful user, does this provider qualify for a hardship exception under §413.70(a)(6)(ii)? Enter "Y" for yes or "N" for no. (see instructions) 168.01 169.00 If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the 9. 99169. 00 transition factor. (see instructions) Begi nni ng Endi ng 1. 00 2.00 170.00 Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting 10/01/2016 12/31/2016 170. 00 period respectively (mm/dd/yyyy) 1.00 2.00 171.00|If line 167 is "Y", does this provider have any days for individuals enrolled in 0171.00 N section 1876 Medicare cost plans reported on Wkst. S-3, Pt. I, line 2, col. 6? Enter "Y" for yes and "N" for no in column 1. If column 1 is yes, enter the number of section 1876 Medicare days in column 2. (see instructions)

SPI T	AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider C	CN: 15-0010		Worksheet S- 7 Part II 8 Date/Time Pr 11/26/2018 1	epared:
				Y/N	Date	
	General Instruction: Enter Y for all YES responses. Enter N	for all NO re	esponses. Ente	1.00 er all dates in	2.00 the	
	mm/dd/yyyy format. COMPLETED BY ALL HOSPITALS		<u> </u>			
00	Provider Organization and Operation Has the provider changed ownership immediately prior to the reporting period? If yes, enter the date of the change in co	beginning of	the cost	N		1.0
	reporting period: 11 yes, enter the date of the change in ec	31 dilii1 2. (300	Y/N	Date	V/I	
00	Has the provider terminated participation in the Medicare Pr yes, enter in column 2 the date of termination and in column		1.00 N	2. 00	3.00	2.0
00	voluntary or "I" for involuntary. Is the provider involved in business transactions, including contracts, with individuals or entities (e.g., chain home of or medical supply companies) that are related to the provide officers, medical staff, management personnel, or members of of directors through ownership, control, or family and other relationships? (see instructions)	ffices, drug er or its f the board	Y			3.0
	Teratronships? (see Thstructions)		Y/N	Туре	Date	
	Financial Data and Reports		1.00	2. 00	3.00	
00	Column 1: Were the financial statements prepared by a Certi Accountant? Column 2: If yes, enter "A" for Audited, "C" foor "R" for Reviewed. Submit complete copy or enter date avail column 3. (see instructions) If no, see instructions.	or Compiled,	Y	A		4.0
00	Are the cost report total expenses and total revenues differ those on the filed financial statements? If yes, submit reco		N			5. C
				1. 00	Legal Oper. 2.00	
	Approved Educational Activities				1 2.00	
00	Column 1: Are costs claimed for nursing school? Column 2: the legal operator of the program?	If yes, is th	ne provider is	S N		6.0
00	Are costs claimed for Allied Health Programs? If "Y" see ins Were nursing school and/or allied health programs approved a cost reporting period? If yes, see instructions.		d during the	Y N		7. C 8. C
00	Are costs claimed for Interns and Residents in an approved of program in the current cost report? If yes, see instructions	5.		N N		9. 0
. 00	Was an approved Intern and Resident GME program initiated or cost reporting period? If yes, see instructions. Are GME cost directly assigned to cost centers other than I			N		10.0
	Teaching Program on Worksheet A? If yes, see instructions.				Y/N 1.00	
	Bad Debts Is the provider seeking reimbursement for bad debts? If yes,	soo instruct	tions		Υ	12. 0
3. 00	If line 12 is yes, did the provider's bad debt collection poperiod? If yes, submit copy.	olicy change o	during this co		N	13. 0
. 00	If line 12 is yes, were patient deductibles and/or co-paymer Bed Complement	nts waived? If	yes, see in:	structi ons.	l N	14.0
. 00	Did total beds available change from the prior cost reportin		yes, see ins		N art B	15.0
		Y/N	Date	Y/N	Date	
	DCOD Doto	1. 00	2.00	3. 00	4. 00	
0. 00	PS&R Data Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 (see	Y	10/08/2018	Y	10/08/2018	16.0
. 00	instructions) Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date	N		N		17. (
. 00	in columns 2 and 4. (see instructions) If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this	N		N		18. 0
00	cost report? If yes, see instructions. If line 16 or 17 is yes, were adjustments made to PS&R	N		N		19. (

Heal th	Financial Systems ST. JOSEPH HOSPITAL	L & HEALTH CEN ⁻	ΓER	In Lie	u of Form CMS	-2552-10		
	AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provi der C		Period: From 07/01/2017 To 06/30/2018	Worksheet S- Part II	2 epared:		
			pti on	Y/N	Y/N			
20. 00	If line 16 or 17 is yes, were adjustments made to PS&R)	1. 00 N	3. 00 N	20.00		
20.00	Report data for Other? Describe the other adjustments:			IN	IN	20.00		
		Y/N	Date	Y/N	Date			
21. 00	Was the cost report prepared only using the provider's	1. 00 N	2. 00	3. 00 N	4. 00	21.00		
21.00	records? If yes, see instructions.	IV.		14		21.00		
					1. 00			
	COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCE	PT CHILDRENS H	OSPI TALS)					
22. 00	Capital Related Cost Have assets been relifed for Medicare purposes? If yes, see	e instructions				22, 00		
23. 00	Have changes occurred in the Medicare depreciation expense		als made dur	ing the cost		23. 00		
	reporting period? If yes, see instructions.			Ü				
24. 00	Were new leases and/or amendments to existing leases entered if yes, see instructions	· ·	·			24. 00		
25. 00	Have there been new capitalized leases entered into during instructions.	the cost repor	ting period?	If yes, see		25. 00		
26. 00	Were assets subject to Sec. 2314 of DEFRA acquired during the instructions.	ne cost reporti	ng period? I	f yes, see		26. 00		
27. 00	Has the provider's capitalization policy changed during the copy.	e cost reportir	g period? If	yes, submit		27. 00		
20.00	Interest Expense	tored into due	ing the cost	rananti na		20.00		
28. 00	Were new loans, mortgage agreements or letters of credit er period? If yes, see instructions. Did the provider have a funded depreciation account and/or		•			28. 00		
29.00	treated as a funded depreciation account? If yes, see instr	•	bt Service R	eserve runa)		29. 00		
30. 00	Has existing debt been replaced prior to its scheduled matu		debt? If yes	, see		30. 00		
31. 00	instructions. 10 Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see							
	instructions. Purchased Services							
32. 00	Have changes or new agreements occurred in patient care ser	rvices furnishe	d through co	ntractual		32. 00		
33. 00	arrangements with suppliers of services? If yes, see instru If line 32 is yes, were the requirements of Sec. 2135.2 app	uctions. Dlied pertainir	g to competi	tive bidding? If		33. 00		
	no, see instructions. Provider-Based Physicians							
34. 00	Are services furnished at the provider facility under an ar	rangement with	provi der-ba	sed physi ci ans?		34. 00		
35. 00	If yes, see instructions. If line 34 is yes, were there new agreements or amended exi		its with the p	provi der-based		35. 00		
	physicians during the cost reporting period? If yes, see in	nstructions.		Y/N	Date			
				1. 00	2. 00			
27.00	Home Office Costs			.,		1, 00		
36. 00 37. 00	Were home office costs claimed on the cost report? If line 36 is yes, has a home office cost statement been pr	cenared by the	home office?	Y		36. 00 37. 00		
	If yes, see instructions.							
38. 00	If line 36 is yes, was the fiscal year end of the home off the provider? If yes, enter in column 2 the fiscal year end			N		38. 00		
39. 00	If line 36 is yes, did the provider render services to othe see instructions.	er chain compor	ents? If yes	, N		39. 00		
40. 00	If line 36 is yes, did the provider render services to the instructions.	home office?	If yes, see	N		40. 00		
		1	00		00			
	Cost Report Preparer Contact Information	1.00 2.						
41. 00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3,	RONALD		HELMS		41. 00		
42. 00	respecti vel y.	ASCENSION HEAL	TH			42. 00		
12 00	preparer.	317-583-3234		RONALD. HELMS@A	SCENSION ODC	43. 00		
43. 00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	517-503-3234		NOWALD. HELMO@A	JOLINJI UIN. UKU	43.00		

Heal th	Financial Systems	ST. JOSEPH HOSPITAL	L & HEALTH C	CENTER	In Lie	u of Form CMS-	2552-10
HOSPI T	TAL AND HOSPITAL HEALTH CARE REIMBURSEMEN	T QUESTI ONNAI RE	Provi der	CCN: 15-0010	Peri od: From 07/01/2017	Worksheet S-2 Part II	
					To 06/30/2018		pared: :03 pm
				3. 00			
	Cost Report Preparer Contact Information	1					
41.00	Enter the first name, last name and the	ti tle/posi ti on	NET REVENUE	MANAGEMENT			41.00
	held by the cost report preparer in colu	umns 1, 2, and 3,	MANAGER				
	respecti vel y.						
42.00	Enter the employer/company name of the o	cost report					42.00
	preparer.	•					
43.00	Enter the telephone number and email add	dress of the cost					43.00
	report preparer in columns 1 and 2, resp	ecti vel y.					
42. 00	Enter the first name, last name and the held by the cost report preparer in colurespectively. Enter the employer/company name of the opreparer. Enter the telephone number and email add	title/position umns 1, 2, and 3, cost report dress of the cost					42.00

| Peri od: | Worksheet S-3 | From 07/01/2017 | Part | To 06/30/2018 | Date/Time Prepared: | Date/Time Prepared Health Financial Systems ST. JOSEPH H
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA ST. JOSEPH HOSPITAL & HEALTH CENTER Provider CCN: 15-0010

					0 06/30/2018	11/26/2018 12	
						I/P Days / 0/P	
						Visits / Trips	
	Component	Worksheet A	No. of Beds	Bed Days	CAH Hours	Title V	
		Line Number		Avai I abl e			
		1. 00	2. 00	3.00	4. 00	5. 00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and	30.00	86	31, 390	0.00	0	1. 00
	8 exclude Swing Bed, Observation Bed and						
	Hospice days)(see instructions for col. 2						
	for the portion of LDP room available beds)						
2.00	HMO and other (see instructions)						2. 00
3.00	HMO IPF Subprovider						3. 00
4.00	HMO IRF Subprovider						4. 00
5.00	Hospital Adults & Peds. Swing Bed SNF					0	5. 00
6.00	Hospital Adults & Peds. Swing Bed NF					0	6. 00
7.00	Total Adults and Peds. (exclude observation		86	31, 390	0.00	0	7. 00
	beds) (see instructions)						
8.00	INTENSIVE CARE UNIT	31. 00	13	4, 745	0.00	0	8. 00
9.00	CORONARY CARE UNIT						9. 00
10.00	BURN INTENSIVE CARE UNIT						10. 00
11. 00	SURGICAL INTENSIVE CARE UNIT						11. 00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY	43. 00				0	13. 00
14.00	Total (see instructions)		99	36, 135	0.00	0	14. 00
15.00	CAH visits					0	15. 00
16.00	SUBPROVI DER - I PF						16. 00
17.00	SUBPROVI DER - I RF	41. 00	18	6, 570)	0	17. 00
18.00	SUBPROVI DER						18. 00
19.00	SKILLED NURSING FACILITY						19. 00
20.00	NURSING FACILITY						20. 00
21. 00	OTHER LONG TERM CARE						21. 00
22.00	HOME HEALTH AGENCY						22. 00
23.00	AMBULATORY SURGICAL CENTER (D. P.)						23. 00
24.00	HOSPI CE						24. 00
24. 10	HOSPICE (non-distinct part)	30. 00					24. 10
25.00	CMHC - CMHC						25. 00
26.00	RURAL HEALTH CLINIC						26. 00
26. 25	FEDERALLY QUALIFIED HEALTH CENTER	89. 00				0	26. 25
27. 00	Total (sum of lines 14-26)		117				27. 00
28. 00	Observation Bed Days					0	28. 00
29. 00	Ambul ance Tri ps						29. 00
30.00	Employee discount days (see instruction)						30. 00
31.00	Employee discount days - IRF						31. 00
32.00	Labor & delivery days (see instructions)		8	2, 920)		32. 00
32. 01	Total ancillary labor & delivery room						32. 01
	outpatient days (see instructions)						
33. 00	LTCH non-covered days						33. 00
33. 01	LTCH site neutral days and discharges						33. 01

33.01

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 15-0010

Peri od: Worksheet S-3 From 07/01/2017 Part I To 06/30/2018 Date/Time Prepared:

11/26/2018 12:03 pm Full Time Equivalents I/P Days / O/P Visits / Trips Title XVIII Component Title XIX Total All Total Interns Employees On Pati ents & Residents Payrol I 10.00 6.00 7.00 8.00 9.00 1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 5, 581 190 14, 748 1.00 8 exclude Swing Bed, Observation Bed and Hospice days) (see instructions for col. 2 for the portion of LDP room available beds) 2 00 HMO and other (see instructions) 2 00 2, 104 4.583 3.00 HMO IPF Subprovider 3.00 HMO IRF Subprovider 4.00 378 107 4.00 5.00 Hospital Adults & Peds. Swing Bed SNF 5.00 0 C Hospital Adults & Peds. Swing Bed NF 6.00 C 0 6.00 7.00 Total Adults and Peds. (exclude observation 5, 581 190 14, 748 7.00 beds) (see instructions) INTENSIVE CARE UNIT 257 8.00 1, 318 1,812 8.00 CORONARY CARE UNIT 9.00 9.00 10.00 BURN INTENSIVE CARE UNIT 10.00 11.00 SURGICAL INTENSIVE CARE UNIT 11.00 12.00 OTHER SPECIAL CARE (SPECIFY) 12.00 13.00 NURSERY 51 2, 162 13.00 527.00 14.00 Total (see instructions) 6,899 498 18, 722 0.00 14.00 CAH visits 15.00 15.00 SUBPROVIDER - IPF 16.00 16.00 SUBPROVIDER - IRF 3, 547 17. 10 17.00 2,475 15 0.00 17.00 18.00 SUBPROVI DER 18.00 19.00 SKILLED NURSING FACILITY 19.00 20 00 NURSING FACILITY 20 00 21.00 OTHER LONG TERM CARE 21.00 22.00 HOME HEALTH AGENCY 22.00 23.00 AMBULATORY SURGICAL CENTER (D. P.) 23.00 HOSPI CE 24 00 24 00 24. 10 HOSPICE (non-distinct part) 0 0 0 24.10 CMHC - CMHC 25.00 25.00 26, 00 RURAL HEALTH CLINIC 26, 00 FEDERALLY QUALIFIED HEALTH CENTER 0.00 26, 25 0.00 26.25 0 Ω 0 27.00 Total (sum of lines 14-26) 0.00 544.10 27.00 28.00 Observation Bed Days 1,031 28.00 2, 197 29.00 Ambul ance Trips 29.00 30.00 Employee discount days (see instruction) 186 30.00 31.00 Employee discount days - IRF 43 31.00 Labor & delivery days (see instructions) Total ancillary labor & delivery room 457 32.00 32.00 0 C 32.01 C32.01 outpatient days (see instructions) 33.00 LTCH non-covered days 0 33.00

33.01 LTCH site neutral days and discharges

Health Financial Systems ST. JOSEPH HOSPITAL & HEALTH CENTER
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA Provider CCN:

Provi der CCN: 15-0010

Peri od: Worksheet S-3
From 07/01/2017 Part I
To 06/30/2018 Date/Time Prepared: 11/26/2018 12:02 pm

							11/26/2018 12	:03 pm
		Full Time Equivalents	·	[)i sch	arges		
	Component	Nonpai d Workers	Title V	Title XVI	П	Title XIX	Total All Patients	
		11. 00	12. 00	13. 00		14. 00	15. 00	
1. 00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days) (see instructions for col. 2 for the portion of LDP room available beds)			0 1	, 771	123	5, 521	1.00
2.00	HMO and other (see instructions)				437	1, 534		2. 00
3.00	HMO IPF Subprovider					0		3. 00
4.00	HMO IRF Subprovider					o		4.00
5.00	Hospital Adults & Peds. Swing Bed SNF							5. 00
6.00	Hospital Adults & Peds. Swing Bed NF							6.00
7. 00	Total Adults and Peds. (exclude observation beds) (see instructions)							7. 00
8. 00	INTENSIVE CARE UNIT							8. 00
9. 00	CORONARY CARE UNIT							9. 00
10. 00	BURN INTENSIVE CARE UNIT							10.00
11. 00	SURGICAL INTENSIVE CARE UNIT							11. 00
12. 00	OTHER SPECIAL CARE (SPECIFY)							12. 00
13. 00	NURSERY							13.00
14. 00	Total (see instructions)	0.00		0 1	, 771	123	5, 521	14. 00
15. 00	CAH visits	0.00		١ '	, , , , ,	123	5, 521	15. 00
16. 00	SUBPROVIDER - IPF							16.00
17. 00	SUBPROVIDER - I RF	0. 00		o	223	14	322	17. 00
18. 00	SUBPROVI DER	0.00		٩	223	14	322	18.00
19. 00	SKILLED NURSING FACILITY			•				19.00
20. 00	NURSING FACILITY			•				20.00
21. 00	OTHER LONG TERM CARE			•				21.00
22. 00								21.00
23. 00	HOME HEALTH AGENCY AMBULATORY SURGICAL CENTER (D.P.)							23. 00
24. 00	HOSPICE							24.00
24. 00	HOSPICE (non-distinct part)							24. 00
25. 00	CMHC - CMHC							25. 00
26. 00	RURAL HEALTH CLINIC							26.00
26. 25		0. 00						26. 00
27. 00	FEDERALLY QUALIFIED HEALTH CENTER	0.00						27. 00
28. 00	Total (sum of lines 14-26)	0.00						28.00
29. 00	Observation Bed Days							29.00
	Ambulance Trips							
30.00	Employee discount days (see instruction)							30.00
31. 00	Employee discount days - IRF							31.00
32.00	Labor & delivery days (see instructions)							32.00
32. 01	Total ancillary labor & delivery room							32. 01
22.00	outpatient days (see instructions)				^			22.00
33.00	LTCH non-covered days LTCH site neutral days and discharges				0			33. 00 33. 01
33.01	TETOT SI LE HEULT di days and di Schal ges	I I		I	U	l		33.01

| Period: | Worksheet S-3 | From 07/01/2017 | Part II | To 06/30/2018 | Date/Time Prepared: Health Financial Systems
HOSPITAL WAGE INDEX INFORMATION ST. JOSEPH HOSPITAL & HEALTH CENTER

Provider CCN: 15-0010

New York Properties New York Properties New York New York Properties New York New						To	06/30/2018	Date/Time Pre	
Page 11 Walfe Parts 1.00 2.00 3.00 4.00 5.			Wkst. A Line	Amount	Recl assi fi cati	Adj usted	Pai d Hours		: 03 piii
No.			Number	Reported					
PART II - BAGE PATA 1.00 2.00 3.00 4.00 5.00 6.00						\		COI. 5)	
### MARIES			1. 00	2. 00				6. 00	
1.00 Incat salaries (see 200 00 35,616,017 117,899 35,733,916 1,131,712 00 31 58 1.00 Incat salaries (see 200 00 0 0 0 0 0 0 0									
Instructions December Decem	1. 00		200. 00	35, 616, 017	117, 898	35, 733, 915	1, 131, 712, 00	31. 58	1. 00
3.00 Non-physician anesthetist Part 4.00 Physician-Part A - 268, 927 0 268, 927 2, 704, 00 99, 46 4, 00 April strative 208, 927 0 268, 927 2, 704, 00 99, 46 4, 00 April strative 208, 927 0 268, 927 2, 704, 00 99, 46 4, 00 April strative 208, 927 0 268, 927 2, 704, 00 99, 46 4, 00 April strative 208, 927 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 April strative 208, 927 0 0 268, 927 2, 704, 00 99, 46 4, 00 April strative 208, 927 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0		instructions)				_			
4. 00 Physician-Part A - Administrative amangament and administrat	2.00	Non-physician anesthetist Part		C	0	0	0.00	0.00	2.00
Administrative 4. 01 Physicians - Porta - Teaching 7.00 Physicians - Porta -	3.00	Non-physician anesthetist Part		C	0	0	0.00	0.00	3. 00
Administrative 4. 01 Physicians - Porta - Teaching 7.00 Physicians - Porta -	4 00	B Dhysician Dart A		249 027		249 027	2 704 00	00 44	4 00
5.00 Physic I can Part B for 0.042,303 0.1,042,303 0.1,0233.00 101.86 5.00 2.00 2.00 2.00 0.	4.00			200, 927		200, 927	2, 704.00	99.40	4.00
Physician-Part B				-	· -	0		•	
Non-physician-Part B for Non-physician-Part	5.00			1, 042, 303	0	1, 042, 303	10, 233. 00	101.86	5.00
Services	6.00	Non-physician-Part B for		C	0	0	0.00	0.00	6. 00
1,00 Interns & residents (In an approved program) 0 0 0 0 0 0 0 0 0									
Contracted interns and residents (in an approved programs)	7. 00		21. 00	C	0	0	0.00	0.00	7. 00
residents (in an approved programs) 8,00 Home office and/or related 2,276,931 0 2,276,931 59,783.00 38,09 8,00 0 0 0 0 0 0 0 0 0	7 01					0	0.00	0.00	7 01
100 100	7.01			C	o o	U	0.00	0.00	7.01
Organization personnel Section Advisor				0 07/ 004		0.07/.004	50 700 00		
9.00 SRÉ Luded area salaries (see instructions) OTHER WAGES & RELATED COSTS 11.00 Contract labor: Direct Patient Contract l	8.00			2, 2/6, 931	0	2, 276, 931	59, 783. 00	38.09	8.00
Instructions OTHER WAGES & RELATED COSTS		SNF	44. 00	C	0	0		•	
OTHER WAGES & RELATED COSTS 10.00 Contract I abor: Top Level management and other management	10. 00	· · · · · · · · · · · · · · · · · · ·		2, 255, 312	224, 464	2, 479, 776	78, 359. 00	31. 65	10. 00
Care Contract Labor: Top Level									
12.00 Contract Labor: Top Level management and other management and other management and administrative services	11. 00			724, 385	0	724, 385	8, 453. 00	85. 70	11. 00
management and administrative Services	12. 00			C	0	0	0.00	0.00	12. 00
Services									
13.00 Contract Labor: Physician - Part 0 0 0 0 0.00 0.00 13.00 14.00 A - Administrative 0 0 0 0 0 0.00 0.00 14.00 14.00 Home office and/or related organization sal aries and wage-related costs 0 0 0 0 0 0 0 0 14.01 Home office sal aries and wage-related costs 0 0 0 0 0 0 0 0 15.00 Home office: Physician Part A 0 0 0 0 0 0 0 0 0									
14. 00 Home office and/or related or	13.00	Contract Labor: Physician-Part		C	0	0	0.00	0. 00	13. 00
organization sal aries and wage-related costs 14. 01 Home office sal aries 6, 928, 420 0 6, 928, 420 156, 482. 00 44. 28 14. 01 14. 02 Rel ated organization sal aries 0 0 0 0 0.00 0.00 15. 00 Home office shysician Part A 0 0 0 0 0.00 0.00 16. 00 Home office and Contract 0 0 0 0 0.00 0.00 17. 00 Wage-related Costs (core) (see instructions) 17. 00 18. 00 Wage-related costs (sther) 0 0 0 0 0 19. 00 Excluded areas 616, 798 0 616, 798 19. 00 20. 00 Non-physician anesthetist Part 0 0 0 0 21. 00 Non-physician anesthetist Part 0 0 0 22. 00 Physician Part A - Teaching 0 0 0 22. 00 Physician Part A - Teaching 0 0 0 23. 00 Physician Part B 256, 988 0 256, 988 23. 00 24. 00 Wage-related costs (final approved program) 0 0 0 25. 50 Core, 25. 51 25. 52 4. 20 4. 20 4. 20 25. 52 4. 20 4. 20 4. 20 4. 20 4. 20 26. 00 Excluded areas 0 0 0 0 27. 52. 52 25. 53 25. 53 26. 00 Excluded areas 0 0 0 26. 00 Core, 25. 50 25. 50 26. 00 Core, 25. 50 25. 50 26. 00 Core, 25. 50 25. 50 27. 50 Core, 25. 50 25. 50 28. 60 Core, 25. 50 25. 50 29. 60 Core, 25. 50 25. 50 29. 60 Core, 25. 50 25. 50 20. 60 Core, 25. 50	14 00	1		C	0	0	0.00	0.00	14 00
14. 01 Home office salaries	14.00			C		J	0.00	0.00	14.00
14. 02 Related organization salaries 0 0 0 0 0 0 0 0 0	14 01			6 029 420		6 029 420	156 492 00	11 20	14 01
- Admin istrative Home office and Contract Home office & Contract Home o		1			1	0, 928, 420		1	
16.00 Home office and Contract Physicians Part A - Teaching MAGE_RELATED COSTS	15. 00			C	0	0	0.00	0.00	15. 00
Physician Part A - Teaching	16. 00			C	0	0	0.00	0.00	16. 00
17.00 Wage-related costs (core) (see instructions) 18.00 Wage-related costs (other) 0 0 0 0 0 18.00 Wage-related costs (other) 0 0 0 0 0 0 0 0 0		Physicians Part A - Teaching							
18.00 Wage-rel ated costs (other)	17. 00			8, 985, 711	O	8. 985. 711			17. 00
19.00 Excl uded areas 616,798 0 616,798 19.00 20.00 Non-physician anesthetist Part		instructions)				2, 122, 111			
19. 00 Excl uded areas 19. 00 20. 00 Non-physician anesthetist Part 20. 00 Non-physician anesthetist Part 21. 00 Non-physician anesthetist Part 21. 00 Non-physician anesthetist Part 21. 00 21. 00 21. 00 21. 00 22. 00 22. 00 22. 00 22. 00 23. 00 24. 00 25. 988 256.	18. 00			C	0	0			18. 00
21.00 Non-physician anesthetist Part 0 0 0 0 0 0 0 0 0	19. 00	·		616, 798	0	616, 798			19. 00
B	20. 00	Non-physician anesthetist Part		C	0	0			20. 00
Administrative Physician Part A - Teaching 0 0 0 22. 01	21. 00	Non-physician anesthetist Part		C	0	0			21. 00
Administrative Physician Part A - Teaching 0 0 0 22. 01	22.00	B Physician Port A		47.207		44 204			22 00
22. 01	ZZ. UU	3		00, 300	ή	00, 306			22.00
24. 00				05.4	· -	0			
25. 00 Interns & residents (in an approved program) 25. 00 25. 50 Home office wage-related (core) 25. 51 Related organization 25. 52 Home office: Physician Part A 0 0 0 0 25. 52 25. 53 Home office & Contract 0 0 0 0 0 25. 53 Physicians Part A - Teaching - wage-related (core) 0 0 0 0 0 0 0 0 0				256, 988 0	0	256, 988 0			
25. 50 Home office wage-related (core) 25. 50 (core) 25. 51 Related organization 25. 51 Wage-related (core) 25. 51 Home office: Physician Part A 0 0 0 0 25. 52 25. 52 25. 53 25. 54 25. 55 25.		Interns & residents (in an		C	Ö	0			
Core	25 50	, , , , , ,		C	0	0			25 50
wage-related (core)	23. 30			C		0			25. 50
25. 52 Home office: Physician Part A	25. 51			C	0	0			25. 51
- Administrative - wage-related (core) Home office & Contract Physicians Part A - Teaching - wage-related (core) OVERHEAD COSTS - DIRECT SALARIES 26.00 Employee Benefits Department	25. 52	, ,		C	o	0			25. 52
25. 53 Home office & Contract 0 0 0 0 25. 53 Physicians Part A - Teaching - wage-related (core) OVERHEAD COSTS - DIRECT SALARIES 26. 00 Employee Benefits Department 4. 00 -40, 019 117, 898 77, 879 2, 336. 00 33. 34 26. 00		- Administrative -							
Physicians Part A - Teaching -	25. 53			C	ا	n			25. 53
OVERHEAD COSTS - DIRECT SALARIES 26.00 Employee Benefits Department 4.00 -40,019 117,898 77,879 2,336.00 33.34 26.00		Physicians Part A - Teaching -		_					
26.00 Employee Benefits Department 4.00 -40,019 117,898 77,879 2,336.00 33.34 26.00			S						
27. 00 Administrative & General 5. 00 4, 519, 849 0 4, 519, 849 109, 608. 00 41. 24 27. 00		Employee Benefits Department	4. 00	•					
	27. 00	Administrative & General	5. 00	4, 519, 849	0	4, 519, 849	109, 608. 00	41. 24	27. 00

Health Financial Systems
HOSPITAL WAGE INDEX INFORMATION Provider CCN: 15-0010

│ Wkst. A Line │ Amount │Reclassificati│ Adjusted │ Paid Hours │Average Ho	^l y
Number Reported on of Salaries Salaries Related to Wage (col.	4 ÷
(from Wkst. (col.2 ± col. Salaries in col. 5)	
A-6) 3) col. 4	
1.00 2.00 3.00 4.00 5.00 6.00	
28. 00 Admi ni strati ve & General under 10, 900, 287 0 10, 900, 287 194, 825. 00 5	. 95 28. 00
contract (see inst.)	
	. 00 29. 00
30.00 Operation of Plant 7.00 292,632 0 292,632 15,875.00 1	. 43 30. 00
31.00 Laundry & Linen Service 8.00 0 0 0 0 0.00	. 00 31. 00
32. 00 Housekeepi ng 9. 00 0 0 0 0. 00	. 00 32. 00
33. 00 Housekeepi ng under contract 1, 474, 830 0 1, 474, 830 68, 078. 00 2	. 66 33. 00
(see instructions)	
34. 00 Di etary 10. 00 0 0 0 0. 00	. 00 34. 00
35. 00 Di etary under contract (see 549, 515 0 549, 515 25, 194. 00 2	. 81 35. 00
instructions)	
36. 00 Cafeteria 11. 00 0 0 0 0. 00	. 00 36. 00
37. 00 Maintenance of Personnel 12. 00 0 0 0 0.00	. 00 37. 00
38.00 Nursing Administration 13.00 1,550,060 0 1,550,060 42,611.00 3	. 38 38. 00
39.00 Central Services and Supply 14.00 0 0 0 0 0	. 00 39. 00
40.00 Pharmacy 15.00 1,742,622 0 1,742,622 41,664.00 4	. 83 40. 00
41.00 Medical Records & Medical 16.00 0 0 0 0	. 00 41. 00
Records Li brary	
42. 00 Social Service 17. 00 0 0 0 0. 00	. 00 42. 00
43.00 Other General Service 18.00 0 0 0 0 0.00	. 00 43. 00

Total overhead cost (see

instructions)

7.00

42. 20

7.00

HOSPITAL WAGE INDEX INFORMATION Worksheet S-3 Part III Date/Time Prepared: Provider CCN: 15-0010 Peri od: From 07/01/2017 To 06/30/2018 11/26/2018 12:03 pm Average Hourly Worksheet A Amount Recl assi fi cati Adj usted Pai d Hours Line Number Reported on of Salaries Sal ari es Related to Wage (col. 4 (col . 2 ± col . (from Salaries in col . 5) Works<u>heet A-6)</u> 3) col. 4 1.00 5.00 6.00 2.00 3.00 4.00 PART III - HOSPITAL WAGE INDEX SUMMARY 1.00 Net salaries (see 45, 221, 415 117, 898 45, 339, 313 1, 349, 793. 00 33. 59 1.00 instructions) 2.00 Excluded area salaries (see 2, 255, 312 2, 479, 776 78, 359. 00 31. 65 2.00 224, 464 instructions) 3.00 Subtotal salaries (line 1 42, 966, 103 -106, 566 42, 859, 537 1, 271, 434. 00 33.71 3.00 minus line 2) 4.00 Subtotal other wages & related 7, 652, 805 7, 652, 805 164, 935. 00 46. 40 4.00 costs (see inst.) Subtotal wage-related costs 5.00 9, 052, 017 C 9, 052, 017 0.00 21.12 5.00 (see inst.) Total (sum of lines 3 thru 5) 6.00 6.00 59, 670, 925 -106, 566 59, 564, 359 1, 436, 369. 00 41 47

117, 898

21, 107, 674

500, 191. 00

20, 989, 776

Health Financial Systems ST. JOSEPH HOSPITAL & HEALTH CENTER In Lieu of Form CMS-2552-10 HOSPITAL WAGE RELATED COSTS Provider CCN: 15-0010 Peri od: Worksheet S-3 From 07/01/2017 Part IV 06/30/2018 Date/Time Prepared: 11/26/2018 12:03 pm Amount Reported 1.00 PART IV - WAGE RELATED COSTS Part A - Core List RETIREMENT COST 1.00 401K Employer Contributions 1, 798, 792 2 00 Tax Sheltered Annuity (TSA) Employer Contribution 0 3.00 Nonqualified Defined Benefit Plan Cost (see instructions) Ω Qualified Defined Benefit Plan Cost (see instructions) 4.00 476, 610 PLAN ADMINISTRATIVE COSTS (Paid to External Organization) 5.00 401K/TSA Plan Administration fees 0 6.00 Legal /Accounting/Management Fees-Pension Plan 0 7.00 Employee Managed Care Program Administration Fees -327, 815 HEALTH AND INSURANCE COST 8.00 Health Insurance (Purchased or Self Funded) 0 8.01 Health Insurance (Self Funded without a Third Party Administrator) 0 8.02 Health Insurance (Self Funded with a Third Party Administrator) 4, 273, 034 Health Insurance (Purchased) 8.03 0 9.00 Prescription Drug Plan 825, 859 Dental, Hearing and Vision Plan 10.00 6, 367 Life Insurance (If employee is owner or beneficiary) -11, 851 11.00 Accident Insurance (If employee is owner or beneficiary) 12.00 -2, 695 Disability Insurance (If employee is owner or beneficiary) 256, 585 14.00 Long-Term Care Insurance (If employee is owner or beneficiary) 71, 886

Health Financial Systems	ST. JOSEPH HOSPITAL &	HEALTH CENTER	In Lieu	u of Form CMS-2552-10
HOSPITAL CONTRACT LABOR AND BENEFIT COST		Provider CCN: 15-0010	From 07/01/2017	Worksheet S-3 Part V Date/Time Prepared: 11/26/2018 12:03 pm

		10 06/30/2018	Date/lime Prep 11/26/2018 12	
	Cost Center Description	Contract Labor		ОО р
	·	1. 00	2. 00	
	PART V - Contract Labor and Benefit Cost			
	Hospital and Hospital-Based Component Identification:			
1.00	Total facility's contract labor and benefit cost	724, 385	9, 925, 803	1. 00
2.00	Hospi tal	724, 385	9, 925, 803	2. 00
3.00	Subprovi der - I PF			3. 00
4.00	Subprovi der - I RF	0	0	4. 00
5.00	Subprovi der - (Other)	0	0	5. 00
6.00	Swing Beds - SNF	0	0	6. 00
7.00	Swing Beds - NF	0	0	7. 00
8.00	Hospi tal -Based SNF			8. 00
9.00	Hospi tal -Based NF			9. 00
10.00	Hospi tal -Based OLTC			10.00
11. 00	Hospi tal -Based HHA			11. 00
12.00	Separately Certified ASC			12. 00
13.00	Hospi tal -Based Hospi ce			13. 00
14.00	Hospital-Based Health Clinic RHC			14. 00
15. 00	Hospital-Based Health Clinic FQHC			15. 00
16.00	Hospi tal -Based-CMHC			16. 00
17. 00	Renal Di al ysi s	0	0	17. 00
18. 00	Other	0	0	18. 00

Heal th	Financial Systems ST. JOSEPH HOSPITAL & F	FALTH CENT	FR	In Lie	u of Form CMS-2	2552-10			
		Provi der CC		Peri od:	Worksheet S-10				
				From 07/01/2017					
				To 06/30/2018		oared:			
					11/26/2018 12	U3 pm			
					1. 00				
	Uncompensated and indigent care cost computation				1.00				
1.00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 div	ided by lin	ne 202 column	ı 8)	0. 227394	1. 00			
	Medicaid (see instructions for each line)			-,					
2.00	2.00 Net revenue from Medicaid								
3.00	Did you receive DSH or supplemental payments from Medicaid?				N	3.00			
4.00	If line 3 is yes, does line 2 include all DSH and/or supplement	al payments	s from Medica	ni d?		4.00			
5.00	If line 4 is no, then enter DSH and/or supplemental payments fr	om Medicai	d		0	5.00			
6.00	Medi cai d charges				82, 691, 621	6.00			
7.00	Medicaid cost (line 1 times line 6)				18, 803, 578	7. 00			
8.00	Difference between net revenue and costs for Medicaid program (line 7 minu	us sum of lir	nes 2 and 5; if	7, 170, 256	8. 00			
	<pre>< zero then enter zero) Children's Health Incurrence Program (CHLD) (see instructions for</pre>	r sook line	-)						
9. 00	Children's Health Insurance Program (CHIP) (see instructions fo Net revenue from stand-alone CHIP	i each iiii	=)		0	9. 00			
10.00	Stand-alone CHIP charges				0	10. 00			
11. 00	Stand-alone CHIP cost (line 1 times line 10)				0	11. 00			
12. 00	Difference between net revenue and costs for stand-alone CHIP (line 11 mi	nus line 9·i	f < zero then	-	12. 00			
.2.00	enter zero)			2010 (11011	Ĭ				
	Other state or local government indigent care program (see inst	ructions fo	or each line)						
13.00	Net revenue from state or local indigent care program (Not incl	uded on li	nes 2, 5 or 9	9)	0	13.00			
14.00	Charges for patients covered under state or local indigent care	program (1	Not included	in lines 6 or	0	14.00			
	10)	_							
15. 00	State or local indigent care program cost (line 1 times line 14		41.1	45 1 11	0	15. 00			
16. 00	Difference between net revenue and costs for state or local ind 13; if < zero then enter zero)	igent care	program (III	ne 15 minus iine	U	16. 00			
	Grants, donations and total unreimbursed cost for Medicaid, CHI	P and state	e/Local indic	ent care program	ns (see				
	instructions for each line)	and State	orrocal inar	jerre eare program	15 (300				
17. 00	Private grants, donations, or endowment income restricted to fu	nding chari	ity care		0	17.00			
18.00	Government grants, appropriations or transfers for support of h	ospital ope	erati ons		0	18.00			
19. 00	Total unreimbursed cost for Medicaid , CHIP and state and local	indigent o	care programs	s (sum of lines	7, 170, 256	19.00			
	8, 12 and 16)								
			Uni nsured	Insured	Total (col. 1				
		-	patients 1.00	pati ents 2.00	+ col . 2) 3.00				
	Uncompensated Care (see instructions for each line)		1.00	2.00	3.00				
20. 00	Charity care charges and uninsured discounts for the entire fac	ility	11, 145, 38	5, 530, 922	16, 676, 307	20. 00			
	(see instructions)		,		.,,				
21.00	Cost of patients approved for charity care and uninsured discou	nts (see	2, 534, 39	5, 530, 922	8, 065, 316	21.00			
	instructions)								
22. 00	Payments received from patients for amounts previously written	off as		0 0	0	22. 00			
22 00	charity care		0 504 0	F F20 022	0.0/5.21/	22.00			
23. 00	Cost of charity care (line 21 minus line 22)		2, 534, 3	5, 530, 922	8, 065, 316	23.00			
					1. 00				
24 00	Does the amount on line 20 column 2, include charges for patien	t days hev	ond a Length	of stay limit	N N	24. 00			
21.00	imposed on patients covered by Medicaid or other indigent care		ond a rength	or stay rrim t	"	21.00			
25.00	00 If line 24 is yes, enter the charges for patient days beyond the indigent care program's length of								
	stay limit	Ü	. •	-					
26. 00									
27. 00	Medicare reimbursable bad debts for the entire hospital complex	•			324, 581	27. 00			
27. 01	Medicare allowable bad debts for the entire hospital complex (s	ee instruc	tions)		499, 356				
28. 00	Non-Medicare bad debt expense (see instructions)				2, 501, 575	28. 00			
29. 00	Cost of non-Medicare and non-reimbursable Medicare bad debt exp	ense (see i	ınstructions)		743, 618				
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)	no 20)			8, 808, 934	30.00			
31.00	Total unreimbursed and uncompensated care cost (line 19 plus li	ne 30)			15, 979, 190	31.00			

CLAS	SSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF	EXPENSES	Provi der Co		eri od:	Worksheet A	
					rom 07/01/2017 o 06/30/2018	Date/Time Pre	
	Cost Center Description	Sal ari es	Other	Total (col. 1 + col. 2)	Reclassificati ons (See A-6)		
	CENEDAL CEDALOE COCT CENTEDO	1. 00	2. 00	3. 00	4. 00	5. 00	
00	GENERAL SERVICE COST CENTERS 00100 CAP REL COSTS-BLDG & FIXT		2, 601, 351	2, 601, 351	565, 323	3, 166, 674	1.
00	00200 CAP REL COSTS-BLDG & TTXT		2, 069, 190			2, 069, 190	1
00	00400 EMPLOYEE BENEFITS DEPARTMENT	-40, 019	8, 664, 133			8, 624, 114	1
00	00500 ADMINISTRATIVE & GENERAL	4, 519, 849	33, 489, 251	38, 009, 100		38, 020, 579	1
00	00700 OPERATION OF PLANT	292, 632	3, 794, 246			4, 086, 878	1
00	00800 LAUNDRY & LINEN SERVICE	0	0		1		1
00	00900 HOUSEKEEPI NG	o	2, 135, 826	2, 135, 826		1, 674, 529	1
00	01000 DI ETARY	O	2, 379, 202	2, 379, 202	-1, 564, 184	815, 018	10.
. 00	01100 CAFETERI A	O	0	C	1, 564, 184	1, 564, 184	11.
. 00	01300 NURSING ADMINISTRATION	1, 550, 060	198, 976	1, 749, 036	0	1, 749, 036	13.
. 00	01500 PHARMACY	1, 742, 622	301, 131	2, 043, 753	0	2, 043, 753	15.
. 00	01600 MEDICAL RECORDS & LIBRARY	0	2, 365		1	2, 365	1
00	02300 ALLI ED HEALTH-RAD TECH PROGRAM	84, 281	34, 169	118, 450	224, 464	342, 914	23
~~	INPATIENT ROUTINE SERVICE COST CENTERS	F 400 000	4 0/0 040	/ 540 403	400.000	/ 000 045	١.,
00	03000 ADULTS & PEDI ATRI CS	5, 180, 238	1, 369, 249				
00	03100 NTENSI VE CARE UNIT 04100 SUBPROVI DER - I RF	1, 260, 101 1, 012, 706	215, 842 131, 605			1, 475, 943 1, 144, 311	
00	04300 NURSERY	1,012,700	131, 603			525, 402	
. 00	ANCI LLARY SERVI CE COST CENTERS	<u> </u>	0		323, 402	323, 402	43
00	05000 OPERATI NG ROOM	3, 714, 760	2, 302, 521	6, 017, 281	0	6, 017, 281	50
00	05200 DELIVERY ROOM & LABOR ROOM	2, 115, 104	436, 065				
00	05400 RADI OLOGY-DI AGNOSTI C	1, 558, 756	1, 085, 048	2, 643, 804	-225, 565	2, 418, 239	54
01	03630 ULTRA SOUND	322, 778	66, 167	388, 945	0	388, 945	54
00	05600 RADI OI SOTOPE	730, 929	465, 537	1, 196, 466	0	1, 196, 466	56
00	05700 CT SCAN	390, 264	49, 760	440, 024	0	440, 024	
00	05800 MAGNETIC RESONANCE IMAGING (MRI)	298, 992	31, 426			330, 418	
00	05900 CARDI AC CATHETERI ZATI ON	70, 165	80, 819	· ·		150, 984	
00	06000 LABORATORY	0	5, 647, 152		1	5, 647, 152	
00	06500 RESPI RATORY THERAPY	1, 171, 050	239, 206			1, 410, 256	
00	06600 PHYSI CAL THERAPY	3, 125, 582	699, 584				
00	06700 OCCUPATI ONAL THERAPY 06800 SPEECH PATHOLOGY	0	0	[C		945, 342	
00	06900 ELECTROCARDI OLOGY	658, 428	100, 404	ĭ	200,0.0	235, 646 758, 832	
00	07000 ELECTROENCEPHALOGRAPHY	402, 697	200, 444	· ·			
00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	280, 388	1, 257, 476			1, 537, 864	
00	07200 I MPL. DEV. CHARGED TO PATIENTS	0	2, 926, 467			2, 926, 467	
00	07300 DRUGS CHARGED TO PATIENTS	ol	4, 514, 098				1
00	07400 RENAL DIALYSIS	o	276, 082			276, 082	
00	03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	1, 330, 419	476, 803	1, 807, 222	. 0	1, 807, 222	76
01	03190 CHEMOTHERAPY	479, 139	15, 908, 687	16, 387, 826	-11, 373, 013	5, 014, 813	76
	03330 ENDOSCOPY	91, 919	119, 784	· ·		211, 703	76
03	03950 WOUND CARE CENTER	225, 151	584, 191	809, 342	-4, 400	804, 942	76
00	OUTPATIENT SERVICE COST CENTERS	4 000 704	007.000	0 405 704		0.405.704	٠,
	09100 EMERGENCY 09200 OBSERVATION BEDS (NON-DISTINCT PART)	1, 888, 701	297, 083	2, 185, 784	0	2, 185, 784	91 92
00	OTHER REIMBURSABLE COST CENTERS						72
00	09500 AMBULANCE SERVICES	776, 126	154, 817	930, 943	0	930, 943	95
	SPECIAL PURPOSE COST CENTERS						
3. 00	11300 I NTEREST EXPENSE		572, 402	572, 402	-572, 402		113
. 00	SUBTOTALS (SUM OF LINES 1 through 117) NONREIMBURSABLE COST CENTERS	35, 233, 818	95, 878, 559	131, 112, 377	0	131, 112, 377	118
). NO	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	O	0	C	ol	n	190
	19100 RESEARCH	o	0	_	1		191
	19200 PHYSI CI ANS' PRI VATE OFFI CES	72, 966	1, 903, 363	_	1	1, 976, 329	
	1 19201 MARKETI NG	0	311				192
	19202 EDUCATION CENTER	0	20, 716			20, 716	
	19300 NONPALD WORKERS	o	0				193
	07950 FOUNDATI ON	O	0	C	o o		194
	07951 ASPR BIOTERRORISM GRANT	0	8, 460			8, 460	194
1. 02	207952 CLINIC OF HOPE TOTAL (SUM OF LINES 118 through 199)	309, 233	62, 533 97, 873, 942			371, 766	
0. 00		35, 616, 017		133, 489, 959	ol Ol	133, 489, 959	

Health FinancialSystemsST.JOSEPH HOSPRECLASSIFICATIONAND ADJUSTMENTS OF TRIALBALANCE OF EXPENSES

Provi der CCN: 15-0010

Peri od: From 07/01/2017 To 06/30/2018 Worksheet A Date/Time Prepared: 11/26/2018 12:03 pm

				11/26/2018	12:03 pm
	Cost Center Description	Adjustments	Net Expenses		
		(See A-8)	For Allocation	<u>n</u>	
		6. 00	7. 00		
	GENERAL SERVICE COST CENTERS				
1.00	00100 CAP REL COSTS-BLDG & FIXT	-552, 671			1.00
2.00	00200 CAP REL COSTS-MVBLE EQUIP	0	_, _,		2. 00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	16, 913			4. 00
5.00	00500 ADMINISTRATIVE & GENERAL	-8, 604, 762			5. 00
7. 00	00700 OPERATION OF PLANT	-22, 259			7. 00
8.00	00800 LAUNDRY & LINEN SERVICE	0			8. 00
9.00	00900 HOUSEKEEPI NG	0	1, 674, 529		9. 00
10.00	01000 DI ETARY	-510, 006			10.00
11. 00	01100 CAFETERI A	0	1, 564, 184		11. 00
13. 00	01300 NURSI NG ADMI NI STRATI ON	-1, 675			13. 00
15. 00	01500 PHARMACY	-11, 219			15. 00
16. 00	01600 MEDICAL RECORDS & LIBRARY	-484			16. 00
23. 00	02300 ALLIED HEALTH-RAD TECH PROGRAM	-23, 325	319, 589	9	23. 00
	I NPATIENT ROUTINE SERVICE COST CENTERS				
30. 00	03000 ADULTS & PEDI ATRI CS	-600, 468		·	30. 00
31.00	03100 I NTENSI VE CARE UNI T	0		·	31.00
41.00	04100 SUBPROVI DER - I RF	-600		·	41.00
43. 00	04300 NURSERY	0	525, 402	2	43. 00
F0 00	ANCILLARY SERVICE COST CENTERS	700			F0 00
50.00	05000 OPERATING ROOM	-702		•	50.00
52. 00	05200 DELIVERY ROOM & LABOR ROOM	-10		•	52. 00
54. 00	05400 RADI OLOGY - DI AGNOSTI C	-27, 322		·	54. 00
54. 01	03630 ULTRA SOUND	100 (01	388, 945	·	54. 01
56. 00	05600 RADI OI SOTOPE	-109, 601	1, 086, 865	·	56. 00
57. 00 58. 00	05700 CT SCAN	0		·	57. 00
59. 00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0			58. 00 59. 00
60.00	05900 CARDI AC CATHETERI ZATI ON 06000 LABORATORY	-655			60.00
65. 00	06500 RESPIRATORY THERAPY	-033			65. 00
66. 00	06600 PHYSI CAL THERAPY	-26, 455			66. 00
67. 00	06700 OCCUPATI ONAL THERAPY	-20, 433			67. 00
68. 00	06800 SPEECH PATHOLOGY				68. 00
69. 00	06900 ELECTROCARDI OLOGY	0	758, 832		69. 00
70. 00	07000 ELECTROENCEPHALOGRAPHY	0	593, 688		70.00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	-1, 003			71. 00
72. 00	07200 I MPL. DEV. CHARGED TO PATIENTS	0			72.00
73. 00	07300 DRUGS CHARGED TO PATIENTS	0			73. 00
74. 00	07400 RENAL DIALYSIS	0			74. 00
76. 00	03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	-579, 225			76. 00
76. 01	03190 CHEMOTHERAPY	-52, 567	4, 962, 246		76. 01
76. 02	03330 ENDOSCOPY	0	211, 703		76. 02
76. 03	1	-2, 956		·	76. 03
	OUTPATIENT SERVICE COST CENTERS	,		-	
91.00		0	2, 185, 784	4	91. 00
92.00					92. 00
	OTHER REIMBURSABLE COST CENTERS		·		
95.00		-9, 266	921, 677	7	95. 00
	SPECIAL PURPOSE COST CENTERS	<u> </u>			
113.00	11300 NTEREST EXPENSE	0	C		113. 00
118.00	l	-11, 120, 318	119, 992, 059	9	118. 00
	NONREI MBURSABLE COST CENTERS				
190.00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	O		190. 00
191.00	19100 RESEARCH	0	0	o	191. 00
192.00	19200 PHYSICIANS' PRIVATE OFFICES	0	1, 976, 329	9	192. 00
192. 0°	1 19201 MARKETI NG	598, 670	598, 981	1	192. 01
	19202 EDUCATION CENTER	0	20, 716		192. 02
	19300 NONPALD WORKERS	0	0	o	193. 00
	07950 FOUNDATION	0	0	o	194. 00
194.01	1 07951 ASPR BIOTERRORISM GRANT	0	8, 460	o	194. 01
194. 02	2 07952 CLINIC OF HOPE	0	371, 766	6	194. 02
200.00	TOTAL (SUM OF LINES 118 through 199)	-10, 521, 648	122, 968, 311	1	200. 00

Health Financial Systems RECLASSIFICATIONS Provider CCN: 15-0010 Peri od: Worksheet A-6 From 07/01/2017 To 06/30/2018 Date/Time Prepared:

					10 00, 30,	11/26/2018 12: 03 pm
		Increases		·		
	Cost Center	Li ne #	Sal ary	0ther		
	2. 00	3.00	4.00	5. 00		
	A - LAUNDRY AND LINEN RECLASS					
1.00	LAUNDRY & LINEN SERVICE	8. 00	0	509, 679		1.00
2.00		0.00	O	0		2. 00
3.00		0.00	O	0		3.00
4.00		0.00	O	0		4. 00
5.00		0.00	0	0		5. 00
6.00		0.00	O	0		6. 00
	TOTALS		0	509, 679		
	B - LABOR DELIVERY_OB_NURSERY	' RECLASS				
1.00	ADULTS & PEDIATRICS	30.00	359, 675	74, 153		1. 00
2.00	NURSERY	43. 00	435, 596	89, 806		2. 00
	TOTALS		795, 271	163, 959		
	C - DIETARY_CAFETERIA RECLASS	<u> </u>				
1.00	CAFETERI A	11. 00	0	<u>1, 564, 1</u> 84		1.00
	TOTALS		0	1, 564, 184		
	D - INTEREST EXPENSE					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	565, 323		1.00
2.00	ADMI NI STRATI VE & GENERAL	5.00		<u>7, 0</u> 79		2. 00
	TOTALS		0	572, 402		
	E - CHEMOTHERAPY DRUG RECLASS					
1. 00	DRUGS CHARGED TO PATIENTS	73.00		<u>11, 373, 0</u> 13		1.00
	TOTALS		0	11, 373, 013		
	F - PT_OT_ST RECLASS					
1. 00	OCCUPATI ONAL THERAPY	67.00	772, 449	172, 893		1.00
2.00	SPEECH PATHOLOGY		19 <u>2, 5</u> 49	4 <u>3, 0</u> 97		2. 00
	TOTALS		964, 998	215, 990		
	G - AH-RAD TECH PRECEPTING EX			_		
1. 00	ALLIED HEALTH-RAD TECH	23. 00	224, 464	0		1. 00
	PROGRAM					
	TOTALS		224, 464	0		
1 00	H - PTO ACCRUAL	4 00	117 000			1 00
1. 00	EMPLOYEE BENEFITS DEPARTMENT TOTALS	4.00	11 <u>7, 8</u> 98 117, 898	<u>0</u>		1.00
		\	117, 898	U		
1. 00	I - RECLASS CONSULTING EXPENS ADMINISTRATIVE & GENERAL	5.00	ما	4, 400		1.00
1.00	TOTALS		 	$-\frac{4,400}{4,400}$		1.00
E00 00	Grand Total: Increases		<u> </u>	14, 403, 627		E00.00
500.00	Juliana rotar: increases	I	2, 102, 631	14, 403, 627		500.00

Health Financial Systems RECLASSIFICATIONS ST. JOSEPH HOSPITAL & HEALTH CENTER Provider CCN: 15-0010 Peri od: Worksheet A-6 From 07/01/2017 To 06/30/2018 Date/Time Prepared:

		D					
		Decreases				1	
	Cost Center	Li ne #	Sal ary	0ther	Wkst. A-7 Ref.		
	6. 00	7. 00	8. 00	9. 00	10. 00		
	A - LAUNDRY AND LINEN RECLASS						
1.00	HOUSEKEEPI NG	9. 00	0	461, 297		0	1. (
2.00	RADI OLOGY-DI AGNOSTI C	54.00	0	1, 101		0	2.0
3.00	PHYSI CAL THERAPY	66.00	0	11, 518	(0	3. 0
4.00	PHYSI CAL THERAPY	66.00	0	14, 437		0	4. 0
5.00	PHYSI CAL THERAPY	66.00	0	11, 873		0	5. (
6.00	ELECTROENCEPHALOGRAPHY	70.00	0	9, 453	(0	6. 0
	TOTALS			509, 679			
	B - LABOR DELIVERY_OB_NURSERY	RECLASS					
1.00	DELIVERY ROOM & LABOR ROOM	52.00	795, 271	163, 959	(O	1. (
2.00		0.00	0	0	(2. 0
	TOTALS		795, 271	163, 959		7	
	C - DIETARY_CAFETERIA RECLASS	•				·	
1.00	DI ETARY	10.00	0	1, 564, 184		0	1. (
	TOTALS			1, 564, 184		7	
	D - INTEREST EXPENSE	•					
1.00	INTEREST EXPENSE	113.00	0	572, 402	1	1	1. (
2.00		0.00	О	0		o	2. (
	TOTALS			572, 402		7	
	E - CHEMOTHERAPY DRUG RECLASS				•	•	
1.00	CHEMOTHERAPY	76. 01	0	11, 373, 013	(O O	1. (
	TOTALS			11, 373, 013		7	
	F - PT OT ST RECLASS	<u> </u>			•	·	
1.00	PHYSI CAL THERAPY	66.00	964, 998	215, 990	(o	1.0
2.00		0.00	0	0			2. 0
	TOTALS		964, 998	215, 990			
	G - AH-RAD TECH PRECEPTING EX	PENSE			II.		
1.00	RADI OLOGY-DI AGNOSTI C	54.00	224, 464	0		0	1. (
	TOTALS	— — †	224, 464				
	H - PTO ACCRUAL		22.7.10.1				
1.00	EMPLOYEE BENEFITS DEPARTMENT	4, 00	0	117, 898		0	1. (
00	TOTALS	— — ° +		117, 898		Ť	
	I - RECLASS CONSULTING EXPENS	F	<u> </u>	117,070			
1.00	WOUND CARE CENTER	76.03	nl	4, 400			1. (
1.00	TOTALS		— — 	4, 400		-	1.0
500 00	Grand Total: Decreases		1, 984, 733	14, 521, 525		†	500. 0

Subtotal (sum of lines 1-7)

Reconciling Items

10.00 Total (line 8 minus line 9)

8.00

9.00

8.00

9.00

10.00

RECONCILIATION OF CAPITAL COSTS CENTERS Provi der CCN: 15-0010 Peri od: Worksheet A-7 From 07/01/2017 Part I 06/30/2018 Date/Time Prepared: 11/26/2018 12:03 pm Acqui si ti ons Begi nni ng Purchases Total Di sposal s and Donati on Bal ances Retirements 2.00 3.00 4. 00 1 00 5 00 PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES 722, 779 1.00 0 1.00 1, 764, 978 0 2.00 Land Improvements 0 0 2.00 0 3.00 56, 139, 890 3.00 Buildings and Fixtures 0 0 4.00 Building Improvements 9, 769, 525 734, 262 734, 262 0 4.00 5.00 Fixed Equipment 21, 765, 515 0 5.00 0 6.00 Movable Equipment 39, 537, 796 1, 751, 118 1, 751, 118 31, 101 6.00 0 7.00 HIT designated Assets 0 7.00 0 8.00 Subtotal (sum of lines 1-7) 129, 700, 483 2, 485, 380 2, 485, 380 31, 101 8.00 9.00 Reconciling Items 0 9.00 2, 485, 380 Total (line 8 minus line 9) 129, 700, 483 2, 485, 380 31, 101 10.00 0 10.00 Endi ng Bal ance Fully Depreci ated Assets 6.00 7.00 PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES 1.00 Land 722, 779 0 1.00 2.00 Land Improvements 1, 764, 978 0 2.00 56, 139, 890 3.00 Buildings and Fixtures 0 3.00 10, 503, 787 0 4.00 Building Improvements 4.00 5.00 Fi xed Equipment 21, 765, 515 0 5.00 Movable Equipment 0 6.00 41, 257, 813 6.00 7.00 HIT designated Assets 0 7.00

132, 154, 762

132, 154, 762

0

0

Health Financial Systems	ST. JOSEPH HOSPITAL &	HEALTH CENTER	In Lie	u of Form CMS-2552-10
RECONCILIATION OF CAPITAL COSTS CENTERS		Provider CCN: 15-0010	Peri od: From 07/01/2017 To 06/30/2018	Worksheet A-7 Part II Date/Time Prepared: 11/26/2018 12:03 pm

				0 06/30/2018	Date/lime Pre 11/26/2018 12	
		SU	IMMARY OF CAPIT	AL		
Cost Center Description	Depreciation	Lease	Interest	Insurance (see		
	9.00	10.00	11. 00	instructions) 12.00	instructions) 13.00	
PART II - RECONCILIATION OF AMOUNTS FROM WORK	SHEET A, COLUM	N 2, LINES 1 ai	nd 2			
1.00 CAP REL COSTS-BLDG & FLXT	2, 601, 351	0	C	0	0	1. 00
2.00 CAP REL COSTS-MVBLE EQUIP	2, 069, 190	0	C	0	0	2. 00
3.00 Total (sum of lines 1-2)	4, 670, 541	0	С	0	0	3. 00
	SUMMARY O	F CAPITAL				
Cost Center Description		Total (1) (sum				
	Capi tal -Rel ate					
	d Costs (see	through 14)				
	instructions) 14.00	15. 00				
PART II - RECONCILIATION OF AMOUNTS FROM WORK			nd 2			
1. 00 CAP REL COSTS-BLDG & FLXT	OILLI A, COLOM	2, 601, 351				1.00
2. 00 CAP REL COSTS-MVBLE EQUIP		2, 069, 190				2.00
3.00 Total (sum of lines 1-2)	o o	4, 670, 541				3. 00

Health Financial Systems	ST. JOSEPH HOSPITAL	L & HEALTH CEN	TER	In Lie	u of Form CMS-2	2552-10
RECONCILIATION OF CAPITAL COSTS CENTERS		Provi der C		Peri od:	Worksheet A-7	
				From 07/01/2017 Fo 06/30/2018	Part III Date/Time Pre	nared:
			'	10 00/30/2010	11/26/2018 12	
	COM	PUTATION OF RA	TIOS	ALLOCATION OF		
Cost Center Description	Gross Assets	Capi tal i zed	Gross Assets	Ratio (see	Insurance	
		Leases	for Ratio	instructions)		
			(col . 1 - col . 2)			
	1. 00	2.00	3, 00	4. 00	5. 00	
PART III - RECONCILIATION OF CAPITAL COS		2.00	0.00	1. 00	0.00	
1. 00 CAP REL COSTS-BLDG & FLXT	87, 674, 930	0	87, 674, 930	0. 689199	0	1.00
2.00 CAP REL COSTS-MVBLE EQUIP	39, 537, 796		39, 537, 796		0	2.00
3.00 Total (sum of lines 1-2)	127, 212, 726	0	127, 212, 726	1. 000000	0	3.00
	ALLOCA	TION OF OTHER (CAPI TAL	SUMMARY 0	F CAPITAL	
Cost Center Description	Taxes	Other	Total (sum of	Depreciation	Lease	
		Capi tal -Rel ate				
	4.00	d Costs	through 7)	0.00	10.00	
PART III - RECONCILIATION OF CAPITAL COS	6. 00	7. 00	8. 00	9. 00	10. 00	
1.00 CAP REL COSTS-BLDG & FIXT	DIS CENTERS		1	2, 614, 003	0	1.00
2. 00 CAP REL COSTS-BUBB & TTXT	0			2, 014, 003	_	2.00
3.00 Total (sum of lines 1-2)	0	1		4, 683, 193	0	3.00
0.00 Total (Sam of Times 1.2)		SI	JMMARY OF CAPI		0	0.00
		0.				
Cost Center Description	Interest	Insurance (see	Taxes (see	Other	Total (2) (sum	
		instructions)	instructions)			
				d Costs (see	through 14)	
				instructions)		
DART III - PECONCILIATION OF CARITAL COS	11.00	12.00	13. 00	14. 00	15. 00	

0 0 0

PART III - RECONCILIATION OF CAPITAL COSTS CENTERS
CAP REL COSTS-BLDG & FIXT

2.00 CAP REL COSTS-MVBLE EQUIP 3.00 Total (sum of lines 1-2)

0 0 0

2, 614, 003 1. 00 2, 069, 190 2. 00 4, 683, 193 3. 00

0 0 0

Health Financial Systems
ADJUSTMENTS TO EXPENSES ST. JOSEPH HOSPITAL & HEALTH CENTER

Provider CCN: 15-0010 Peri od: Worksheet A-8 From 07/01/2017 To 06/30/2018 Date/Time Prepared:

					0 06/30/2018	Date/lime Prep 11/26/2018 12:	
				Expense Classification on			
				To/From Which the Amount is	to be Adjusted		
	Cost Center Description	Basis/Code (2)	Amount	Cost Center	Li ne #	Wkst. A-7 Ref.	
1.00	1	1.00	2. 00	3.00	4. 00	5. 00	4 00
1. 00	Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)		0	CAP REL COSTS-BLDG & FIXT	1.00	0	1. 00
2.00	Investment income - CAP REL		0	CAP REL COSTS-MVBLE EQUIP	2.00	o	2. 00
	COSTS-MVBLE EQUIP (chapter 2)		·			آ ا	
3.00	Investment income - other		0		0.00	0	3. 00
4 00	(chapter 2)		•		0.00		4 00
4. 00	Trade, quantity, and time discounts (chapter 8)		0		0.00	0	4. 00
5.00	Refunds and rebates of		0		0.00	o	5. 00
	expenses (chapter 8)						
6.00	Rental of provider space by		0		0.00	0	6.00
7.00	suppliers (chapter 8)	Б	14 000	ADMINICEDATIVE & CENEDAL	F 00		7 00
7. 00	Telephone services (pay stations excluded) (chapter	В	-14,000	ADMINISTRATIVE & GENERAL	5. 00	0	7. 00
	21)						
8.00	Television and radio service	A	-8, 595	ADMINISTRATIVE & GENERAL	5. 00	О	8. 00
	(chapter 21)						
9.00	Parking lot (chapter 21)		0		0.00	0	9. 00
10. 00	Provi der-based physician adjustment	A-8-2	-1, 478, 407			0	10. 00
11. 00	Sale of scrap, waste, etc.		0		0.00	o	11. 00
11.00	(chapter 23)		0		0.00	Ĭ	11.00
12.00	Related organization	A-8-1	641, 923			o	12.00
	transactions (chapter 10)						
13.00	Laundry and linen service		0	51.57451/	0.00	0	
14. 00 15. 00	Cafeteria-employees and guests		-466, 286	DIETARY	10.00	0	14. 00 15. 00
13.00	Rental of quarters to employee and others		U		0.00	0	15.00
16.00	Sale of medical and surgical		0		0.00	0	16. 00
	supplies to other than						
47.00	patients			5,145,146,07	45.00		47.00
17. 00	Sale of drugs to other than patients	В	-11, 219	PHARMACY	15. 00	0	17. 00
18. 00	Sale of medical records and	В	-484	MEDICAL RECORDS & LIBRARY	16. 00	o	18. 00
	abstracts			INCOME NEGOTION & ELDIUMN	.0.00	Ĭ	10.00
19.00	Nursing and allied health	В	-23, 325	ALLIED HEALTH-RAD TECH	23. 00	o	19. 00
	education (tuition, fees,			PROGRAM			
20. 00	books, etc.) Vending machines	В	27 003	DIFTADY	10.00		20.00
21. 00	Income from imposition of	В	-20, U83 N	DI ETARY	10. 00 0. 00		20. 00 21. 00
21.00	interest, finance or penalty		O		0.00	Ĭ	21.00
	charges (chapter 21)						
22. 00	Interest expense on Medicare		0		0.00	0	22. 00
	overpayments and borrowings to						
23. 00	repay Medicare overpayments Adjustment for respiratory	A-8-3	0	RESPI RATORY THERAPY	65. 00		23. 00
23.00	therapy costs in excess of	A-0-3	0	INCOLUMN TILLIAN I	03.00		23.00
	limitation (chapter 14)						
24. 00	Adjustment for physical	A-8-3	0	PHYSICAL THERAPY	66. 00		24. 00
	therapy costs in excess of						
25. 00	limitation (chapter 14) Utilization review -		0	*** Cost Center Deleted ***	114. 00		25. 00
25.00	physicians' compensation		0	Sost Solitor Bereteu	114.00		20.00
	(chapter 21)						
26. 00	Depreciation - CAP REL		0	CAP REL COSTS-BLDG & FIXT	1.00	0	26. 00
27.00	COSTS-BLDG & FLXT		^	CAD DEL COSTS MUDIE FOLLIS	2.00	ا	27 00
27. 00	Depreciation - CAP REL COSTS-MVBLE EQUIP		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	27. 00
28. 00	Non-physician Anesthetist		0	*** Cost Center Deleted ***	19. 00		28. 00
29. 00	Physicians' assistant		0		0.00	0	29. 00
30. 00	Adjustment for occupational	A-8-3	0	OCCUPATI ONAL THERAPY	67. 00		30. 00
	therapy costs in excess of						
30. 99	limitation (chapter 14) Hospice (non-distinct) (see		0	ADULTS & PEDIATRICS	30. 00		30. 99
50.77	instructions)		U	PROCES & LEDIATRICS	30.00		JU. 17
31. 00	Adjustment for speech	A-8-3	0	SPEECH PATHOLOGY	68. 00		31.00
	pathology costs in excess of						
22.00	limitation (chapter 14)		_		0.00		22.00
32. 00	CAH HIT Adjustment for Depreciation and Interest		0		0.00	0	32. 00
33. 00	MEALS ON WHEELS	В	-17. 637	DI ETARY	10. 00	n	33. 00
-	·	. '					

Health Financial Systems ADJUSTMENTS TO EXPENSES Provider CCN: 15-0010 Peri od: Worksheet A-8 From 07/01/2017 | To 06/30/2018 | Date/Time Prepared:

Expense Classification on Worksheet A 10/26/2018 12, 23 pm					To	06/30/2018		
To/From Which the Amount is to be Adjusted To/From Which the Amount is the Amount					Evnense Classification on	Worksheet A	11/20/2018 12	: U3 piii
Cost Center Description Basis st/Code (2) Anount Cost Center Line # Nost A - 7 Ref.								
3.01 OTHER ADJUSTMENTS (SPECIFY)						,		
3.01 OTHER ADJUSTMENTS (SPECIFY)								
3.01 OTHER ADJUSTMENTS (SPECIFY)								
3.01 OTHER ADJUSTMENTS (SPECIFY)								
33.01 OTHER ADJUSTMENTS (SPECIFY)		Cost Center Description						
33 02 BULDING RENTAL			1. 00					
33 02 BUILLIN MG RENTAL B -16,997 DEPARTION OF PLANT 7.00 0 33,02	33. 01			0		0. 00	0	33. 01
INCOME - PROPERTY MMT				44 007	0.0000471.011.00	7.00		
B	33. 02		В	-16, 997	OPERATION OF PLANT	7.00	O	33. 02
INCOME - CHEMOTHERAPY 33. 04 BULLIN MS RENTAL INCOME - WOUND B -2, 956 WOUND CARE CENTER 76. 03 0 33. 04	22 02		D	21 000	CHEMOTHEDADY	76 01	0	22 02
33. 04 SUIL DING RENTAL INCOME-WOUND B -2,956 MOUND CARE CENTER 76. 03 0 33. 04	33. 03		D	-21, 900	CHEWOTHERAPT	76.01	U	33.03
CARE 33. 05 BUILDING RENTAL INCOME-MAMMOGRAPHY 33. 06 ADMIN INSTRATIVE & GENERAL INCOME-MAMMOGRAPHY 33. 06 ADMIN INSTRATIVE FEES B -33 ADMINISTRATIVE & GENERAL 5. 00 33. 06 33. 07 MISC. INCOME LORP UNIT B -10 DELIVERY ROOM & LABOR ROOM 52. 00 03. 33. 07 03. 08 MISC. INCOME DERONITOR NURSING UNIT 33. 09 MISC. INCOME ACUTE CARE REHAB B -30, 667 CHEMOTHERAPY 76. 01 03. 30 03. 10 MISC. INCOME ACUTE CARE REHAB B -600 SUBPROVI DER - I INF 41. 00 03. 31. 10 MISC. INCOME FROU REHAB B -5, 659 PHYSICAL THERAPY 66. 00 03. 31. 13 31. 14 MISC. INCOME FROU REHAB B -2, 715 PHYSICAL THERAPY 66. 00 03. 31. 13 31. 15 MISC. INCOME SURGERY B -702 OPERATING ROOM 50. 00 03. 31. 14 MISC. INCOME RADIOLOGY B -702 OPERATING ROOM 50. 00 03. 31. 14 MISC. INCOME RADIOLOGY B -702 OPERATING ROOM 50. 00 03. 31. 16 MISC. INCOME RADIOLOGY B -702 OPERATING ROOM 50. 00 03. 31. 16 MISC. INCOME RADIOLOGY B -702 OPERATING ROOM 50. 00 03. 31. 16 MISC. INCOME RADIOLOGY B -702 OPERATING ROOM 50. 00 03. 31. 16 MISC. INCOME RADIOLOGY B -702 OPERATING ROOM 50. 00 03. 31. 16 MISC. INCOME RADIOLOGY B -702 OPERATING ROOM 50. 00 03. 31. 16 MISC. INCOME CARDIOLOGY B -702 OPERATING ROOM 50. 00 03. 31. 16 MISC. INCOME CARDIOLOGY B -702 OPERATING ROOM 50. 00 03. 31. 16 MISC. INCOME CARDIOLOGY B -702 OPERATING ROOM 50. 00 03. 31. 16 MISC. INCOME CARDIOLOGY B -702 OPERATING ROOM 50. 00 03. 31. 16 MISC. INCOME CARDIOLOGY B -702 OPERATING ROOM 50. 00 03. 31. 16 MISC. INCOME CARDIOLOGY B -703 OPERATING ROOM 50. 00 03. 31. 16 MISC. INCOME CARDIOLOGY B -703 OPERATING ROOM 50. 00 03. 31. 16 MISC. INCOME CARDIOLOGY B -704 OPERATING ROOM 50. 00 03. 31. 16 MISC. INCOME CARDIOLOGY B -704 OPERATING ROOM 50. 00 03. 31. 18 MISC. INCOME CARDIOLOGY B -705 LABORATORY 60. 00 03. 31. 18 MISC. INCOME CARDIOLOGY B -705 LABORATORY 60. 00 03. 32. 00 MISC. INCOME CARDIOLOGY B -705 LABORATORY 60. 00 03. 32. 00 MISC. INCOME CARDIOLOGY B -705 LABORATORY 60. 00 03. 32. 00 MISC. INCOME CARDIOLOGY B -705 LABORATORY 60. 00 03. 32. 00 MISC. INCOME CARDIOLOGY B -706 OPERATING ROOM 50. 00 03. 32.	33 ∩4	1	B	-2 956	WOLIND CARE CENTER	76.03	0	33 04
BUILDING RENTAL B -2,205 RADI OLOGY-DIA GNOSTIC 54,00 0 33,05	00.01			2, 700	WOOND STATE SERVER	70.00	Ĭ	00.01
NCOME_MAMMOGRAPHY	33. 05	Al C	В	-2, 205	RADI OLOGY-DI AGNOSTI C	54.00	0	33. 05
33. 07 MSC. INCOME LDRP UNIT B -10 DELIVERY ROOM & LABOR ROOM 0 33. 07 0 0 0 33. 08 0 0 0 33. 08 0 0 0 33. 08 0 0 0 33. 08 0 0 0 33. 08 0 0 0 33. 08 0 0 0 33. 08 0 0 0 33. 08 0 0 0 33. 08 0 0 0 33. 08 0 0 0 33. 08 0 0 0 33. 08 0 0 0 33. 08 0 0 0 33. 08 0 0 0 33. 08 0 0 0 33. 08 0 0 0 33. 08 0 0 0 33. 08 0 0 0 33. 10 0 0 0 33. 10 0 0 0 33. 10 0 0 0 33. 10 0 0 0 33. 11 0 0 0 33. 10 0 0 0 33. 11 0 0 0 33. 11 0 0 0 33. 11 0 0 0 0 33. 11 0 0 0 0 0 0 0 0 0		I NCOME-MAMMOGRAPHY						
MISC INCOME PSYCHIATRIC B -15,337 ADULTS & PEDIATRICS 30,00 0 33,08	33.06	ADMINISTRATIVE FEES	В	-35	ADMINISTRATIVE & GENERAL	5. 00	0	33. 06
NURSING UNIT 3. 09 MISC I NCOME ONCOLOGY SVS B B -30.667CHEMOTHERAPY 76.01 0 33.09 33.10 MISC I NCOME ACUTE CARE REHAB B -600 SUBPROVIDER - LRF 41.00 0 33.10 33.11 MISC I NCOME SOUTHWAY REHAB B -5.628 PHYSICAL THERAPY 66.00 0 33.11 33.13 MISC I NCOME FOREST PARK REHAB B -2.715 PHYSICAL THERAPY 66.00 0 33.12 33.13 MISC I NCOME FOREST PARK REHAB B -2.715 PHYSICAL THERAPY 66.00 0 33.13 34.14 MISC I NCOME FOREST PARK REHAB B -18.115 PHYSICAL THERAPY 66.00 0 33.13 35.14 MISC I NCOME FOREST PARK REHAB B -18.115 PHYSICAL THERAPY 66.00 0 33.13 36.15 MISC I NCOME AMBULANCE B -7.02 DEPARTING ROOM 50.00 0 33.15 31.64 MISC I NCOME AMBULANCE B -9.266 AMBULANCE SERVICES 95.00 0 33.15 31.64 MISC I NCOME MANAGRAPHY B -2.942 RADIOLOGY DIAGNOSTIC 54.00 0 33.15 31.75 MISC I NCOME MANAGRAPHY B -6.416 RADIOLOGY DIAGNOSTIC 54.00 0 33.17 31.86 MISC I NCOME MANAGRAPHY B -6.55 LABORATORY 60.00 0 33.17 31.81 MISC I NCOME MANAGRAPHY B -6.55 LABORATORY 60.00 0 33.19 31.81 MISC I NCOME MANAGRAPHY B -6.55 LABORATORY 60.00 0 33.19 31.83 MISC I NCOME MANAGRAPHY B -6.55 LABORATORY 60.00 0 33.19 31.83 MISC I NCOME MANAGRAPHY B -6.55 LABORATORY 60.00 0 33.19 31.84 MISC I NCOME HUMAN RESOURCES B -2.25 EMPLOYEE BENEFITS DEPARTMENT 4.00 0 33.20 31.87 MISC I NCOME HUMAN RESOURCES B -2.25 EMPLOYEE BENEFITS DEPARTMENT 4.00 0 33.21 31.83 MISC I NCOME HUMAN RESOURCES B -2.25 EMPLOYEE BENEFITS DEPARTMENT 7.00 0 33.23 31.24 MISC I NCOME WINDER INTERN PRG B -16.163 ADMIN ISTRATIVE & GENERAL 5.00 0 33.23 31.24 MISC I NCOME SWITCHBOARD B -16.163 ADMIN ISTRATIVE & GENERAL 5.00 0 33.23 31.25 MISC I NCOME SWITCHBOARD B -16.163 ADMIN ISTRATIVE & GENERAL 5.00 0 33.23 31.26 MISC I NCOME SWITCHBOARD B -16.163 ADMIN ISTRATIVE & GENERAL 5.00 0 33.23 31.26 MISC I NCOME SWITCHBOARD B -16.163 ADMIN ISTRATIVE & GENERAL 5.00 0 33.23 31.26 MISC I NCOME SWITCHBOARD B -16.163 ADMIN ISTRATIVE & GENERAL 5.00 0 33.33 31.34 MISC I NCOME SWITCHBOARD B -16.163 ADMIN ISTRATIVE & GENERAL 5.00 0 33.33 31.34 MISC I NCOME SWITCHBOARD B -16.163 ADMIN ISTRATIVE & GENERAL 5.00 0 33.33 31.	33. 07	MISC. INCOME LDRP UNIT	В	-10	DELIVERY ROOM & LABOR ROOM	52.00	0	33. 07
33 .0 MISC INCOME ONCOLOGY SVS B -30,667 CHEMOTHERAPY 76,01 0 33,09	33. 08		В	-15, 337	ADULTS & PEDIATRICS	30.00	0	33. 08
MISC INCOME ACUITE CARE REHAB B -600 SUBPROVI DER - I RF 41.00 0 33.10 33.10 33.11 MISC INCOME SUDITHMAY REHAB B -5.625 PHYSI CAL THERAPY 66.00 0 33.11 33.12 MISC INCOME FOREST PARK REHAB B -2.715 PHYSI CAL THERAPY 66.00 0 33.12 33.13 MISC INCOME FOREST PARK REHAB B -18.115 PHYSI CAL THERAPY 66.00 0 33.13 33.14 MISC INCOME FOREST PARK REHAB B -7.02 DPERATI NG ROOM 50.00 0 33.14 33.15 MISC INCOME AMBULANCE B -7.02 DPERATI NG ROOM 50.00 0 33.15 33.16 MISC INCOME AMBULANCE B -2.9.26 AMBULANCE SERVI CES 95.00 0 33.16 33.16 MISC INCOME MAIMOGRAPHY B -6.416 RADI DLOGY-DI AGNOSTI C 54.00 0 33.16 33.17 MISC INCOME CORPORATE B -6.55 LABORATORY 60.00 0 33.19 TANASACTI ONS 7.00 7.		II .						
MISC INCOME SOUTHWAY REHAB B				· ·	1		-	
33. 12 MISC INCOME PERU REHAB B -2, 715 PHYSICAL THERAPY 66, 00 0 33. 12							_	
33. 14 MISC INCOME FOREST PARK REHAB B -18, 115 PHYSICAL THERAPY 50.00 0 33. 13 33. 14 MISC INCOME SURGERY B -70.20 PERATING ROOM 50.00 0 33. 15 33. 15 MISC INCOME AMBULANCE B -9, 266 AMBULANCE SERVICES 95.00 0 33. 15 33. 16 MISC INCOME RADIOLOGY B -2, 942 RADIOLOGY-DIAGNOSTIC 54.00 0 33. 16 33. 17 MISC INCOME LABORATORY B -6, 416 RADIOLOGY-DIAGNOSTIC 54.00 0 33. 16 33. 18 MISC INCOME LABORATORY B -6, 416 RADIOLOGY-DIAGNOSTIC 54.00 0 33. 18 33. 19 MISC INCOME CORPORATE B 20, 702 AMIN ISTRATIVE & GENERAL 5.00 0 33. 19 33. 20 MISC INCOME EMPLOYEE EDUCATION B -1, 255 EMPLOYEE BENEFITS DEPARTMENT 4.00 0 33. 21 33. 21 MISC INCOME EMPLOYEE EDUCATION B -1, 623 OPERATION OF PLANT 7.00 0 33. 21 33. 22 MISC INCOME SUMMER INTERN PRG B -16, 163 AMIN ISTRATIVE & GENERAL 5.00 0 33. 23 33. 24 MISC INCOME SUMMER INTERN PRG B -2, 100 AMIN ISTRATIVE & GENERAL 5.00 0 33. 24 33. 25 MISC INCOME UNCLAIMED PROPERTY B -7, 849 AMIN ISTRATIVE & GENERAL 5.00 0 33. 25 33. 26 ARCHIVERY EXPENSE A -8, 434, 484 ADMIN ISTRATIVE & GENERAL 5.00 0 33. 27 33. 29 MARKETING EXPENSE A -3, 439 ADMIN ISTRATIVE & GENERAL 5.00 0 33. 27 33. 29 MARKETING EXPENSE A -3, 439 ADMIN ISTRATIVE & GENERAL 5.00 0 33. 28 33. 20 COROPORATE SPONSORSHIP OFFSET A -3, 439 ADMIN ISTRATIVE & GENERAL 5.00 0 33. 32 33. 31 ARKETING EXPENSE A -1, 250 ADMIN ISTRATIVE & GENERAL 5.00 0 33. 32 33. 32 CARRETING EXPENSE A -3, 439 ADMIN ISTRATIVE & GENERAL 5.00 0 33. 32 33. 33 CARRETING EXPENSE A -3, 439 ADMIN ISTRATIVE & GENERAL 5.00 0 33. 32 33. 34 REVERSE FY17 STARP FICA TRUE D A -3, 439 ADMIN ISTRATIVE & GENERAL 5.00 0 33. 33 33. 34 REVERSE FY17 STARP FICA TRUE D A -3, 439 ADMIN ISTRATIVE & GENERAL 5.00 0 33. 33 33. 35 CARRETING EXPENSE A			•	· ·	1		l ~	
33. 15 MISC INCOME SURGERY B -702 OPERATI NG ROOM 50. 00 0 33. 14		II	•					
33. 15 MISC INCOME AMBULANCE B -9, 266 AMBULANCE SERVICES 95. 00 0 33. 15 33. 16 MISC INCOME RADIOLOGY B -2, 942 RADIOLOGY-DIAGNOSTIC 54. 00 0 33. 15 33. 17 MISC INCOME MAMMOGRAPHY B -6, 416 RADIOLOGY-DIAGNOSTIC 54. 00 0 33. 17 33. 18 MISC INCOME LABORATORY B -6, 651 LABORATORY 60. 00 0 33. 18 33. 19 MISC INCOME CORPORATE B 20, 702 ADMINISTRATIVE & GENERAL 5. 00 0 33. 19 33. 20 MISC INCOME EMPLOYEE EDUCATION B -1, 255 EMPLOYEE BENEFITS DEPARTMENT 4. 00 0 33. 20 33. 21 MISC INCOME PLANT OPERATION B -1, 623 OPERATION OF PLANT 7. 00 0 33. 21 33. 22 MISC INCOME PLANT OPERATION B -1, 623 OPERATION OF PLANT 7. 00 0 33. 23 33. 24 MISC INCOME SWITCHBOARD B -1, 63 ADMINISTRATIVE & GENERAL 5. 00 0 33. 24 33. 25 MISC INCOME UNCLAIMED PROPERTY B -7, 849 ADMINISTRATIVE & GENERAL 5. 00 0 33. 25 33. 26 MISC INCOME UNCLAIMED PROPERTY B -7, 849 ADMINISTRATIVE & GENERAL 5. 00 0 33. 26 33. 27 TELEVISION UTILLITIES OFFSET A -8, 434, 484 ADMINISTRATIVE & GENERAL 5. 00 0 33. 27 33. 32 CHARLITABLE DONATIONS OFFSET A -8, 434, 484 ADMINISTRATIVE & GENERAL 5. 00 0 33. 27 33. 33 CORPOPARTE SPONSORSHIP OFFSET A -3, 639 OPERATION OF PLANT 7. 00 0 33. 27 33. 33 CHARLITABLE DONATIONS OFFSET A -3, 639 OPERATION OF PLANT 7. 00 0 33. 39 33. 34 REVERSE FY17 STARP FICA TRUE A 11, 250 ADMINISTRATIVE & GENERAL 5. 00 0 33. 30 33. 34 REVERSE FY17 STARP FICA TRUE A 18, 393 EMPLOYEE BENEFITS DEPARTMENT 4. 00 0 33. 31 33. 35 LOBBYING EXPENSE A -1, 139 ADMINISTRATIVE & GENERAL 5. 00 0 33. 32 33. 36 INVESTMENT INCOME AGE B -7, 799 ADMINISTRATIVE & GENERAL 5. 00 0 33. 35 33. 36 INVESTMENT INCOME AGE B -7, 799 ADMINISTRATIVE & GENERAL 5. 00 0 33. 35 33. 37 INVESTMENT INCOME AGE B -7, 799 ADMINISTRATIVE & GENERAL 5. 00 0 33. 35				· ·	1		_	
33. 16 MISC INCOME RADIOLOGY B -2,942 RADIOLOGY-DIAGNOSTIC 54.00 0 33. 16 33. 17 MISC INCOME MAMMOGRAPHY B -6,416 RADIOLOGY-DIAGNOSTIC 54.00 0 33. 17 33. 18 MISC INCOME LABORATORY B -6,55 LABORATORY 60.00 0 33. 18 33. 19 MISC INCOME CORPORATE B 20,702 ADMINISTRATIVE & GENERAL 5.00 0 33. 19 33. 20 MISC INCOME EMPLOYEE EDUCATION B -1,255 EMPLOYEE BENEFITS DEPARTMENT 4.00 0 33. 20 33. 21 MISC INCOME HUMAN RESOURCES B -225 EMPLOYEE BENEFITS DEPARTMENT 4.00 0 33. 21 33. 22 MISC INCOME PLANT OPERATION B -1,630 DEPARTION OF PLANT 7.00 0 33. 22 33. 23 MISC INCOME SWITCHBOARD B -16,163 ADMINISTRATIVE & GENERAL 5.00 0 33. 23 33. 24 MISC INCOME SWITCHBOARD B -2,100 ADMINISTRATIVE & GENERAL 5.00 0 33. 25 33. 25 MISC INCOME SWIMER INTERN PRG B -2,100 ADMINISTRATIVE & GENERAL 5.00 0 33. 25 33. 25 MISC INCOME SWIMER INTERN PRG B -2,100 ADMINISTRATIVE & GENERAL 5.00 0 33. 25 33. 25 MISC INCOME SWIMER INTERN PRG B -2,100 ADMINISTRATIVE & GENERAL 5.00 0 33. 25 33. 26 PROVIDER TAX EXPENSE A -8,434,484 ADMINISTRATIVE & GENERAL 5.00 0 33. 26 33. 27 TELEVISION UTILITIES OFFSET A -3,639 OPERATION OF PLANT 7.00 0 33. 26 33. 29 MARKETING EXPENSE OFFSET A -3,419 ADMINISTRATIVE & GENERAL 5.00 0 33. 38 33. 30 CORPORATE SPONSORSHIP OFFSET A -3,419 ADMINISTRATIVE & GENERAL 5.00 0 33. 39 33. 31 ATECHER SPONSORSHIP OFFSET A -2,632 ADMINISTRATIVE & GENERAL 5.00 0 33. 39 33. 32 LATE FEES AND PENALTIES OFFSET A -1,039 ADMINISTRATIVE & GENERAL 5.00 0 33. 39 33. 33 REVERSE FY17 STARP FICA TRUE A 5,000 0 33. 32 33. 34 REVERSE FY17 STARP FICA TRUE A 5,000 0 33. 32 33. 35 LOBBYING EXPENSE A -1,139 ADMINISTRATIVE & GENERAL 5.00 0 33. 35 33. 36 INVESTMENT INCOME CARD B -7,079 ADMINISTRATIVE & GENERAL 5.00 0 33. 3		II	•		1		l ~	
33. 17 MISC INCOME MAMMOGRAPHY B -6.416 RADI OLOGY-DI AGNOSTI C 54. 00 0 33. 17 33. 18 MISC INCOME LABORATORY B -6.55 LABORATORY 60. 00 0 33. 18 33. 19 MISC INCOME CORPORATE B 20. 702 ADMI NI STRATI VE & GENERAL 5. 00 0 33. 18 33. 20 MISC INCOME EMPLOYEE EDUCATION B -1,255 EMPLOYEE BENEFITS DEPARTMENT 4. 00 0 33. 20 33. 21 MISC INCOME HUMAN RESOURCES B -225 EMPLOYEE BENEFITS DEPARTMENT 7. 00 0 33. 21 33. 22 MISC INCOME PLANT OPERATION B -1,632 OPERATION OF PLANT 7. 00 0 33. 22 33. 23 MISC INCOME SWITCHBOARD B -16,163 ADMIN ISTRATI VE & GENERAL 5. 00 0 33. 23 33. 24 MISC INCOME SUMMER INTERN PRG B -2,100 ADMIN ISTRATI VE & GENERAL 5. 00 0 33. 24 33. 25 MISC INCOME UNCLAIMED PROPERTY B -7,849 ADMIN ISTRATI VE & GENERAL 5. 00 0 33. 25 33. 26 PROVI DER TAX EXPENSE A -8,434,484 ADMIN ISTRATI VE & GENERAL 5. 00 0 33. 25 33. 29 MARKETING EXPENSE OFFSET A -3,639 OPERATION OF PLANT 7. 00 0 33. 27 33. 30 CORPOPARTE SPONSORSHIP OFFSET A -11,250 ADMIN ISTRATI VE & GENERAL 5. 00 0 33. 29 33. 31 ANALYSE A -3,419 ADMIN ISTRATI VE & GENERAL 5. 00 0 33. 29 33. 32 MARKETING EXPENSE OFFSET A -11,250 ADMIN ISTRATI VE & GENERAL 5. 00 0 33. 30 33. 31 ANALYSE A -26,128 ADMIN ISTRATI VE & GENERAL 5. 00 0 33. 30 33. 32 A S S S S S S S S S		II		· ·	1		ľ	
33. 18 MISC INCOME LABORATORY B 20, 702 ADMINISTRATIVE & GENERAL 5.00 0 33. 18					i i			
MI SC I INCOME CORPORATE TRANSACTI ONS T		II					· -	
TRANSACTIONS 33. 20 MISC INCOME EMPLOYEE EDUCATION B -1, 255 EMPLOYEE BENEFITS DEPARTMENT 4. 00 0 33. 20 MISC INCOME HUMAN RESOURCES B -225 EMPLOYEE BENEFITS DEPARTMENT 7. 00 0 33. 21 33. 22 MISC INCOME PLANT OPERATION B -1, 623 OPERATION OF PLANT 7. 00 0 33. 22 33. 23 MISC INCOME SWITCHBOARD B -16, 163 ADMIN ISTRATI VE & GENERAL 5. 00 0 33. 23 33. 24 MISC INCOME SWIMER INTERN PRG B -2, 100 ADMIN ISTRATI VE & GENERAL 5. 00 0 33. 24 33. 25 MISC INCOME SWIMER INTERN PRG B -2, 100 ADMIN ISTRATI VE & GENERAL 5. 00 0 33. 25 33. 26 PROVIDER TAX EXPENSE A -8, 434, 484 ADMIN ISTRATI VE & GENERAL 5. 00 0 33. 26 33. 27 TELEVI SI ON UTILLITIES OFFSET A -3, 639 OPERATION OF PLANT 7. 00 0 33. 27 33. 28 CHARI TABLE DONATI ONS OFFSET A -11, 250 ADMIN IN STRATI VE & GENERAL 5. 00 0 33. 28 33. 29 MARKETING EXPENSE OFFSET A -3, 419 ADMIN IN STRATI VE & GENERAL 5. 00 0 33. 28 33. 30 COROPORATE SPONSORSHI P OFFSET A -26, 128 ADMIN IN STRATI VE & GENERAL 5. 00 0 33. 31 AHA LI VE OFFSET A -26, 128 ADMIN IN STRATI VE & GENERAL 5. 00 0 33. 31 AMA LI VE OFFSET A -1, 003 MEDICAL SUPPLIES CHARGED TO 71. 00 9 33. 31 DAMA LI VE OFFSET A -1, 003 MEDICAL SUPPLIES CHARGED TO 71. 00 9 33. 31 AMA LI VE OFFSET A -1, 003 MEDICAL SUPPLIES CHARGED TO 71. 00 9 33. 31 DAMA REVERSE FY17 STARP TRUE UP A 50, 540 ADMIN IN STRATI VE & GENERAL 5. 00 0 33. 32 DAMA REVERSE FY17 STARP TRUE UP A 50, 540 ADMIN IN STRATI VE & GENERAL 5. 00 0 33. 34 DAMA LI VE OFFSET A -1, 139 ADMIN IN STRATI VE & GENERAL 5. 00 0 33. 34 DAMA LI VE OFFSET A -1, 139 ADMIN IN STRATI VE & GENERAL 5. 00 0 33. 35 DAMA REVERSE FY17 STARP FICA TRUE UP A 50, 540 ADMIN IN STRATI VE & GENERAL 5. 00 0 33. 35 DAMA REVERSE FY17 STARP FICA TRUE UP A 50, 540 ADMIN IN STRATI VE & GENERAL 5. 00 0 33. 35 DAMA REVERSE FY17 STARP FICA TRUE UP A 50, 540 ADMIN IN STRATI VE & GENERAL 5. 00 0 33. 35 DAMA REVERSE FY17 STARP FICA TRUE UP A 50, 540 ADMIN IN STRATI VE & GENERAL 5. 00 0 33. 35 DAMA REVERSE FY17 STARP FICA TRUE UP A 50, 540 ADMIN IN STRATI VE & GENERAL 5. 00 0 33. 35 DAMA REVERSE FY17 STARP F							l ~	
33. 20 MI SC I NCOME EMPLOYEE EDUCATION B -1, 255 EMPLOYEE BENEFITS DEPARTMENT 4, 00 0 33, 20 33. 21 MI SC I NCOME HUMAN RESOURCES B -225 EMPLOYEE BENEFITS DEPARTMENT 4, 00 0 33, 21 33. 22 MI SC I NCOME PLANT OPERATION B -1, 623 OPERATION OF PLANT 7, 00 0 33, 22 33. 23 MI SC I NCOME SWITCHBOARD B -16, 163 ADMI NI STRATI VE & GENERAL 5, 00 0 33, 23 33. 24 MI SC I NCOME SUMMER I NTERN PRG B -2, 100 ADMI NI STRATI VE & GENERAL 5, 00 0 33, 24 33. 25 MI SC I NCOME UNCLAI MED PROPERTY B -7, 849 ADMI NI STRATI VE & GENERAL 5, 00 0 33, 25 33. 26 PROVI DER TAX EXPENSE A -8, 434, 484 ADMI NI STRATI VE & GENERAL 5, 00 0 33, 25 33. 27 TELEVI SI ON UTI LITIES OFFSET A -11, 250 ADMI NI STRATI VE & GENERAL 5, 00 0 33, 27 33. 28 CHARITABLE DONATIONS OFFSET A -11, 250 ADMI NI STRATI VE & GENERAL 5, 00 0 33, 28 33. 29 MARKETI NG EXPENSE OFFSET A -11, 250 ADMI NI STRATI VE & GENERAL 5, 00 0 33, 28 33. 30 COROPORATE SPONSORSHI P OFFSET A -26, 128 ADMI NI STRATI VE & GENERAL 5, 00 0 33, 30 33. 31 ATALLI VE OFFSET A -12, 652 CAP REL COSTS-BLDG & FIXT 1, 00 9 33, 31 33. 32 LATE FEES AND PENALTIES OFFSET A -1, 003 MEDI CAL SUPPLIES CHARGED TO 71, 00 9 33, 33 33. 33 REVERSE FY17 STARP TRUE UP A 50, 540 ADMI NI STRATI VE & GENERAL 5, 00 0 33, 33 33. 34 REVERSE FY17 STARP FICA TRUE A 18, 393 EMPLOYEE BENEFITS DEPARTMENT 4, 00 0 33, 35 33. 35 LOBBYI NG EXPENSE A -1, 005 MDI NI STRATI VE & GENERAL 5, 00 0 33, 35 33. 36 INVESTMENT I NCOME CAPITAL B -565, 332 CAP REL COSTS-BLDG & FIXT 1, 00 0 33, 35 33. 36 INVESTMENT I NCOME CAPITAL B -565, 332 CAP REL COSTS-BLDG & FIXT 1, 00 0 33, 35 33. 36 INVESTMENT I NCOME CAPITAL B -565, 332 CAP REL COSTS-BLDG & FIXT 1, 00 0 33, 35 33. 37 TOTAL (sum of I ines 1 thru 49) (Transfer to Worksheet A, colum	33. 17		, b	20, 702	ADMINISTRATIVE & GENERAL	3.00		33. 17
33. 21 MI SC I NCOME HUMAN RESOURCES B -225 EMPLOYEE BENEFITS DEPARTMENT 4.00 0 33. 21 33. 22 MI SC I NCOME PLANT OPERATION B -1, 623 OPERATION OF PLANT 7.00 0 33. 22 33. 23 MI SC I NCOME SWITCHBOARD B -16, 163 JADMIN IN STRATI VE & GENERAL 5.00 0 33. 23 33. 24 MI SC I NCOME SUMMER INTERN PRG B -2, 100 ADMIN IN STRATI VE & GENERAL 5.00 0 33. 24 33. 25 MI SC I NCOME UNCLAI MED PROPERTY B -7, 849 ADMIN IN STRATI VE & GENERAL 5.00 0 33. 25 33. 27 TELEVI SI ON UTILLITIES OFFSET A -8, 434, 484 ADMIN IN STRATI VE & GENERAL 5.00 0 33. 27 33. 28 CHARITABLE DONATI ONS OFFSET A -3, 639 OPERATI ON OF PLANT 7.00 0 33. 27 33. 30 COROPORATE SPONSORSHIP OFFSET A -3, 419 ADMIN IN STRATI VE & GENERAL 5.00 0 33. 29 33. 30 COROPORATE SPONSORSHIP OFFSET A -26, 128 ADMIN IN STRATI VE & GENERAL 5.00 0 33. 30 33. 31 AHA LI VE OFFSET A -1, 003 MEDI CAL SUPPLIES CHARGED TO PATI ENTS 33. 33 REVERSE FY17 STARP TRUE UP A 50, 540 ADMIN IN STRATI VE & GENERAL 5.00 0 33. 32 33. 34 REVERSE FY17 STARP FICA TRUE A 50, 540 ADMIN IN STRATI VE & GENERAL 5.00 0 33. 33 33. 35 LOBBYI NG EXPENSE A -1, 139 ADMIN IN STRATI VE & GENERAL 5.00 0 33. 34 33. 35 LOBBYI NG EXPENSE A -1, 139 ADMIN IN STRATI VE & GENERAL 5.00 0 33. 35 33. 35 LOBBYI NG EXPENSE A -1, 139 ADMIN IN STRATI VE & GENERAL 5.00 0 33. 35 33. 36 INVESTMENT I NCOME CAPITAL B -565, 323 CAP REL COSTS-BLDG & FIXT 1.00 11 33. 36 33. 37 INVESTMENT I NCOME CAPITAL B -7, 079 ADMIN IN STRATI VE & GENERAL 5.00 0 33. 37 50. 00 TOTAL (sum of I lines 1 thru 49) (Transfer to Worksheet A, column 6, I ine 200.)	33 20		B	-1 255	EMPLOYEE BENEFLTS DEPARTMENT	4 00	0	33 20
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33. 27 TELEVISION UTILITIES OFFSET A -3, 639 OPERATION OF PLANT 7. 00 0 33. 27 33. 28 CHARITABLE DONATIONS OFFSET A -11, 250 ADMINISTRATIVE & GENERAL 5. 00 0 33. 28 33. 29 MARKETING EXPENSE OFFSET A -26, 128 ADMINISTRATIVE & GENERAL 5. 00 0 33. 29 33. 30 COROPORATE SPONSORSHIP OFFSET A -26, 128 ADMINISTRATIVE & GENERAL 5. 00 0 33. 29 33. 31 AHA LIVE OFFSET A 12, 652 CAP REL COSTS-BLDG & FIXT 1. 00 9 33. 31 33. 32 LATE FEES AND PENALTIES OFFSET A -1, 003 MEDICAL SUPPLIES CHARGED TO PATIENTS 33. 33 REVERSE FY17 STARP TRUE UP A 50, 540 ADMINISTRATIVE & GENERAL 5. 00 0 33. 32 33. 34 REVERSE FY17 STARP FICA TRUE UP A 18, 393 EMPLOYEE BENEFITS DEPARTMENT 4. 00 0 33. 34 33. 35 LOBBYING EXPENSE A -1, 139 ADMINISTRATIVE & GENERAL 5. 00 0 33. 35 33. 36 INVESTMENT INCOME CAPITAL B -565, 323 CAP REL COSTS-BLDG & FIXT 1. 00 11 33. 36 33. 37 INVESTMENT INCOME A&G B -7, 079 ADMINISTRATIVE & GENERAL 5. 00 0 33. 37 50. 00 TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)	33. 25	MISC INCOME UNCLAIMED PROPERTY	В	-7, 849	ADMINISTRATIVE & GENERAL	5. 00	0	33. 25
33. 28 CHARITABLE DONATIONS OFFSET A -11, 250 ADMINISTRATIVE & GENERAL 5. 00 0 33. 28 33. 29 MARKETING EXPENSE OFFSET A -3, 419 ADMINISTRATIVE & GENERAL 5. 00 0 33. 29 33. 30 COROPORATE SPONSORSHIP OFFSET A -26, 128 ADMINISTRATIVE & GENERAL 5. 00 0 33. 30 33. 31 AHA LIVE OFFSET A 12, 652 CAP REL COSTS-BLDG & FIXT 1. 00 9 33. 31 33. 32 LATE FEES AND PENALTIES OFFSET A -1, 003 MEDICAL SUPPLIES CHARGED TO PATIENTS 71. 00 0 33. 32 33. 33 REVERSE FY17 STARP TRUE UP A 50, 540 ADMINISTRATIVE & GENERAL 5. 00 0 33. 33 33. 34 REVERSE FY17 STARP FICA TRUE A 18, 393 EMPLOYEE BENEFITS DEPARTMENT 4. 00 0 33. 34 33. 35 LOBBYING EXPENSE A -1, 139 ADMINISTRATIVE & GENERAL 5. 00 0 33. 35 33. 36 INVESTMENT INCOME CAPITAL B -565, 323 CAP REL COSTS-BLDG & FIXT 1. 00 11 33. 36 33. 37 INVESTMENT INCOME A&G B -7, 079 ADMINISTRATIVE & GENERAL 5. 00 0 33. 37 50. 00 TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)	33. 26		A	-8, 434, 484	ADMINISTRATIVE & GENERAL	5. 00	0	33. 26
33. 29 MARKETING EXPENSE OFFSET A -3, 419 ADMINISTRATIVE & GENERAL 5. 00 0 33. 29 33. 30 COROPORATE SPONSORSHIP OFFSET A -26, 128 ADMINISTRATIVE & GENERAL 5. 00 0 33. 30 33. 31 AHA LIVE OFFSET A 12, 652 CAP REL COSTS-BLDG & FIXT 1. 00 9 33. 31 33. 32 LATE FEES AND PENALTIES OFFSET A -1, 003 MEDICAL SUPPLIES CHARGED TO PATIENTS 1. 00 0 33. 32 33. 33 REVERSE FY17 STARP TRUE UP A 50, 540 ADMINISTRATIVE & GENERAL 5. 00 0 33. 33 33. 34 REVERSE FY17 STARP FICA TRUE A 18, 393 EMPLOYEE BENEFITS DEPARTMENT 4. 00 0 33. 34 33. 35 LOBBYING EXPENSE A -1, 139 ADMINISTRATIVE & GENERAL 5. 00 0 33. 35 33. 36 INVESTMENT INCOME CAPITAL B -565, 332 CAP REL COSTS-BLDG & FIXT 1. 00 11 33. 36 33. 37 INVESTMENT INCOME A&G 5. 00 0 33. 37 50. 00 TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)			•				0	
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33. 31 AHA LIVE OFFSET A 12, 652 CAP REL COSTS-BLDG & FIXT 1.00 9 33. 31 13. 32 LATE FEES AND PENALTIES OFFSET A -1,003 MEDICAL SUPPLIES CHARGED TO 71.00 0 33. 32 PATIENTS 33. 33 REVERSE FY17 STARP TRUE UP A 50,540 ADMINISTRATIVE & GENERAL 5.00 0 33. 34 REVERSE FY17 STARP FICA TRUE A 18,393 EMPLOYEE BENEFITS DEPARTMENT 4.00 0 33. 34 UP 33. 35 LOBBYING EXPENSE A -1,139 ADMINISTRATIVE & GENERAL 5.00 0 33. 35 1NVESTMENT INCOME CAPITAL B -565,323 CAP REL COSTS-BLDG & FIXT 1.00 11 33. 36 1NVESTMENT INCOME A&G B -7,079 ADMINISTRATIVE & GENERAL 5.00 0 33. 37 1NVESTMENT INCOME A&G B -7,079 ADMINISTRATIVE & GENERAL 5.00 0 33. 37 1 TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)			•			5. 00	0	
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33. 33 REVERSE FY17 STARP TRUE UP A 50, 540 ADMINISTRATIVE & GENERAL 5.00 0 33. 33 33. 34 REVERSE FY17 STARP FICA TRUE UP A 18, 393 EMPLOYEE BENEFITS DEPARTMENT 4.00 0 33. 34 33. 35 LOBBYING EXPENSE A -1, 139 ADMINISTRATIVE & GENERAL 5.00 0 33. 35 33. 36 INVESTMENT INCOME CAPITAL B -565, 323 CAP REL COSTS-BLDG & FIXT 1.00 11 33. 36 33. 37 INVESTMENT INCOME A&G B -7, 079 ADMINISTRATIVE & GENERAL 5.00 0 33. 37 50. 00 TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)	33. 32	LAIL FEES AND PENALTIES OFFSET	A	-1, 003		71. 00	0	33. 32
33. 34 REVERSE FY17 STARP FICA TRUE UP 33. 35 LOBBYING EXPENSE A -1, 139 ADMINISTRATIVE & GENERAL 5. 00 0 33. 35 33. 36 INVESTMENT INCOME CAPITAL B -565, 323 CAP REL COSTS-BLDG & FIXT 1. 00 11 33. 36 33. 37 INVESTMENT INCOME A&G B -7, 079 ADMINISTRATIVE & GENERAL 5. 00 0 33. 37 50. 00 TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)	33 33	REVERSE EY17 STARP TRUE UP	Δ	50 540	1	5 00	n	33 33
UP 33. 35 LOBBYING EXPENSE A -1, 139 ADMINISTRATIVE & GENERAL 5. 00 0 33. 35 33. 36 INVESTMENT INCOME CAPITAL B -565, 323 CAP REL COSTS-BLDG & FIXT 1. 00 11 33. 36 33. 37 INVESTMENT INCOME A&G B -7, 079 ADMINISTRATIVE & GENERAL 5. 00 0 33. 37 50. 00 TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)			1	· ·	1			
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50.00 TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)	33. 36	INVESTMENT INCOME CAPITAL	В	-565, 323	CAP REL COSTS-BLDG & FIXT	1.00	11	33. 36
(Transfer to Worksheet A, column 6, line 200.)	33. 37	INVESTMENT INCOME A&G	В	-7, 079	ADMINISTRATIVE & GENERAL	5.00	0	33. 37
column 6, line 200.)	50.00	TOTAL (sum of lines 1 thru 49)		-10, 521, 648				50. 00

⁽¹⁾ Description - all chapter references in this column pertain to CMS Pub. 15-1.
(2) Basis for adjustment (see instructions).
A. Costs - if cost, including applicable overhead, can be determined.
B. Amount Received - if cost cannot be determined.
(2) Additional divisions to the cost cannot be determined.

⁽³⁾ Additional adjustments may be made on lines 33 thru 49 and subscripts thereof.

Note: See instructions for column 5 referencing to Worksheet A-7.

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME OFFICE COSTS

Provider CCN: 15-0010 | Period: | From 07/01/2017

Worksheet A-8-1

OITICL				To 06/30/2018	Date/Time Pre	
	Li ne No.	Cost Center	Expense I tems	Amount of	Amount	
				Allowable Cost	Included in	
					Wks. A, column	
					5	
	1.00	2.00	3.00	4.00	5. 00	
	A. COSTS INCURRED AND ADJUSTM HOME OFFICE COSTS:					
1.00	1	EMPLOYEE BENEFITS DEPARTMENT		1, 159, 114	1, 159, 114	1.00
2.00	II	ADMINISTRATIVE & GENERAL	SVH CHARGEBACK	83, 978	83, 978	2.00
3.00		PHARMACY	SVH CHARGEBACK	-60, 468	-60, 468	3.00
3. 01		MEDICAL RECORDS & LIBRARY	SVH CHARGEBACK	-502	-502	3. 01
3. 02		ALLIED HEALTH-RAD TECH PROGR		27, 204	27, 204	3. 02
3. 03		INTENSIVE CARE UNIT	SVH CHARGEBACK	175	175	3. 03
4.00		RADI OLOGY-DI AGNOSTI C	SVH CHARGEBACK	75, 026	75, 026	4. 00
4. 01		RADI OI SOTOPE	SVH CHARGEBACK	25, 908	25, 908	4. 01
4.02			SVH CHARGEBACK	5, 000	5, 000	4. 02
4. 03		ELECTROCARDI OLOGY	SVH CHARGEBACK	10, 000	10, 000	4. 03
4.04	1	CHEMOTHERAPY	SVH CHARGEBACK	3, 704	3, 704	4. 04
4. 05		EMERGENCY	SVH CHARGEBACK	175	175	4. 05
4.06	192. 00	PHYSICIANS' PRIVATE OFFICES	SVH CHARGEBACK	1, 850, 756	1, 850, 756	4. 06
4.07		ADMINISTRATIVE & GENERAL	SVH MANAGEMENT FEE	25, 598, 357	25, 555, 104	4. 07
4.08		MARKETI NG	SVH MARKETING	598, 670	0	4. 08
4.09			SVH INTEREST EXPENSE	565, 323	565, 323	4. 09
4. 10	5. 00	ADMINISTRATIVE & GENERAL	SVH INTEREST EXPENSE	7, 079	7, 079	4. 10
4. 11	0.00			0	0	4. 11
4. 12	0.00			0	0	4. 12
4. 13	0.00	l .		0	0	4. 13
4.14	0.00			0	0	4. 14
5.00	TOTALS (sum of lines 1-4).			29, 949, 499	29, 307, 576	5.00
	Transfer column 6, line 5 to					
	Worksheet A-8, column 2, line 12.					
					, , , ,	

* The amounts on lines 1-4 (and subscripts as appropriate) are transferred in detail to Worksheet A, column 6, lines as appropriate. Positive amounts increase cost and negative amounts decrease cost. For related organization or home office cost which has not been posted to Worksheet A, columns 1 and/or 2, the amount allowable should be indicated in column 4 of this part.

•					
			Related Organization(s) and/	or Home Office	
			ŭ , ,		
Symbol (1)	Name	Percentage of	Name	Percentage of	
3 , , ,		Ownershi p		Ownershi p	
1. 00	2. 00	3. 00	4. 00	5. 00	
B. INTERRELATIONSHIP TO RELAT	ED ORGANIZATION(S) AND/OR HO	ME OFFICE:			
	. ,				

The Secretary, by virtue of the authority granted under section 1814(b)(1) of the Social Security Act, requires that you furnish the information requested under Part B of this worksheet.

This information is used by the Centers for Medicare and Medicaid Services and its intermediaries/contractors in determining that the costs applicable to services, facilities, and supplies furnished by organizations related to you by common ownership or control represent reasonable costs as determined under section 1861 of the Social Security Act. If you do not provide all or any part of the request information, the cost report is considered incomplete and not acceptable for purposes of claiming reimbursement under title XVIII.

6. 00	В	0. 00 ASCENSI ON 100. 00	6.00
7.00	В	0.00 SV HEALTH 100.00	7.00
8. 00		0.00	8.00
9.00		0.00	9.00
10.00		0.00	10.00
100.00	G. Other (financial or		100.00
	non-financial) specify:		

- (1) Use the following symbols to indicate interrelationship to related organizations:
- A. Individual has financial interest (stockholder, partner, etc.) in both related organization and in provider.
- B. Corporation, partnership, or other organization has financial interest in provider.
- C. Provider has financial interest in corporation, partnership, or other organization.
- D. Director, officer, administrator, or key person of provider or relative of such person has financial interest in related organization.
- E. Individual is director, officer, administrator, or key person of provider and related organization.
- F. Director, officer, administrator, or key person of related organization or relative of such person has financial interest in provider.

* The amounts on lines 1-4 (and subscripts as appropriate) are transferred in detail to Worksheet A, column 6, lines as appropriate. Positive amounts increase cost and negative amounts decrease cost. For related organization or home office cost which has not been posted to Worksheet A, columns 1 and/or 2, the amount allowable should be indicated in column 4 of this part.

4.10

4. 11

4.12

4.13

4 14

5.00

Related Organization(s)		
and/or Home Office		
Type of Business		
Type of business		
/ 00		
6. 00		
D INTERDELATIONSHIP TO DELAT	TED ORGANIZATION(S) AND/OR HOME OFFICE:	
 B. INTERRELATIONSHIP TO RELAT	LED ORGANIZATION(S) AND/OR HOWE OFFICE:	

The Secretary, by virtue of the authority granted under section 1814(b)(1) of the Social Security Act, requires that you furnish the information requested under Part B of this worksheet.

This information is used by the Centers for Medicare and Medicaid Services and its intermediaries/contractors in determining that the costs applicable to services, facilities, and supplies furnished by organizations related to you by common ownership or control represent reasonable costs as determined under section 1861 of the Social Security Act. If you do not provide all or any part of the request information, the cost report is considered incomplete and not acceptable for purposes of claiming reimbursement under title XVIII.

	HEALTH MGMT	6. 00
	HEALTH MGMT	7. 00
8.00		8. 00
9.00		9. 00
10.00		10.00
8. 00 9. 00 10. 00 100. 00		100.00

- (1) Use the following symbols to indicate interrelationship to related organizations:
- A. Individual has financial interest (stockholder, partner, etc.) in both related organization and in provider.
- B. Corporation, partnership, or other organization has financial interest in provider.
- C. Provider has financial interest in corporation, partnership, or other organization.
- D. Director, officer, administrator, or key person of provider or relative of such person has financial interest in related organization.
- E. Individual is director, officer, administrator, or key person of provider and related organization.
- F. Director, officer, administrator, or key person of related organization or relative of such person has financial interest in provider.

0

0

0

0

0

4.10

4.11

4.12

4.13

4.14

5.00

0

0

0

PROVIDER BASED PHYSICIAN ADJUSTMENT

Provider CCN: 15-0010

Peri od: Worksheet A-8-2 From 07/01/2017 To 06/30/2018 Date/Time Prepared:

11/26/2018 12:03 pm Wkst. A Line # Cost Center/Physician Total Professi onal Provi der RCE Amount Physi ci an/Prov Identi fi er ider Component Remuneration Component Component Hours 1. 00 2.00 3. 00 4.00 5. 00 6. 00 7. 00 220, 880 1.00 5.00 DR. A 148, 816 72,064 211, 500 721 1.00 2.00 13. 00 DR. B 1, 675 1, 675 0 2.00 3.00 30.00 DR. C 20, 800 20,800 0 3.00 0 4.00 76.00 DR. D 216, 253 216, 253 0 0 4.00 5. 00 DR. E 5.00 38, 200 38, 200 0 0 5.00 6.00 30.00 DR. F 564, 331 564, 331 0 6.00 56.00 DR. G 7.00 126, 464 95, 838 30, 626 271, 900 129 7.00 54. 00 DR. H 8.00 15, 759 271, 900 12, 798 8.00 28, 557 149 9.00 76. 00 DR. I 362, 300 362, 300 0 9.00 10.00 76.00 DR. J 672 672 0 10.00 1, 580, 132 999 115, 488 200.00 200.00 1, 464, 644 Wkst. A Line # Cost Center/Physician Unadjusted RCE 5 Percent of Provi der Physician Cost Cost of I denti fi er Limit Unadjusted RCE Memberships & Component of Malpractice Limit Conti nui ng Share of col. Insurance Educati on 12 1. 00 2.00 8.00 9.00 12. 00 13.00 14.00 1. 00 1.00 5. 00 DR. A 73.313 3,666 0 0 2.00 13. 00 DR. B 0 0 2.00 3.00 30.00 DR. C 0 0 0 3.00 0 0 0 4.00 76.00 DR. D 0 0 0 0 0 0 0 0 0 4.00 5.00 DR. E 5.00 0 0 5 00 6.00 30.00 DR. F 6.00 7.00 56.00 DR. G 16, 863 843 0 0 7.00 54.00 DR. H 0 0 8.00 19, 478 974 8.00 76. 00 DR. I 0 9.00 0 9.00 10.00 76. 00 DR. J 0 10.00 200.00 109, 654 5, 483 200.00 Wkst. A Line # Cost Center/Physician Provi der Adjusted RCE RCE Adjustment I denti fi er Component Limit Di sal I owance Share of col. 14 1. 00 2.00 15. 00 16. 00 17. 00 18. 00 73, 313 1. 00 1.00 5. 00 DR. A 148, 816 0 0 2.00 13. 00 DR. B 0 0 1, 675 2.00 3.00 30.00 DR. C 0 0 20,800 3.00 76. 00 DR. D 5. 00 DR. E 0 4.00 0 216, 253 4.00 0 5.00 0 0 38, 200 5 00 0 6.00 30.00 DR. F 564, 331 6.00 7.00 56.00 DR. G 16, 863 13, 763 109, 601 7.00 0 54.00 DR. H 19, 478 15, 759 8.00 8.00 76. 00 DR. I 9.00 Λ 0 362, 300 9.00 10.00 76. 00 DR. J 0 672 10.00 200.00 109, 654 13, 763 1, 478, 407 200.00

COST ALLOCATION - GENERAL SERVICE COSTS Provider CCN: 15-0010 Peri od: Worksheet B From 07/01/2017 Part I 06/30/2018 Date/Time Prepared: 11/26/2018 12:03 pm CAPITAL RELATED COSTS Cost Center Description Net Expenses BLDG & FIXT MVBLE EQUIP **EMPLOYEE** Subtotal for Cost **BENEFITS** DEPARTMENT Allocation (from Wkst A col. 7) 1.00 2.00 4. 00 4A GENERAL SERVICE COST CENTERS 1 00 2, 614, 003 00100 CAP REL COSTS-BLDG & FLXT 2, 614, 003 1 00 2.00 00200 CAP REL COSTS-MVBLE EQUIP 2,069,190 2, 069, 190 2.00 4.00 00400 EMPLOYEE BENEFITS DEPARTMENT 8, 641, 027 101, 111 245 8, 742, 383 4.00 00500 ADMINISTRATIVE & GENERAL 8. 195 30, 927, 460 5 00 29, 415, 817 395, 240 1, 108, 208 5 00 00700 OPERATION OF PLANT 7.00 4,064,619 362, 723 151, 077 71, 750 4, 650, 169 7.00 8.00 00800 LAUNDRY & LINEN SERVICE 509, 679 4, 085 513, 764 8.00 9.00 00900 HOUSEKEEPI NG 1,674,529 15, 892 5,838 o 1, 696, 259 9.00 01000 DI ETARY 10.00 305.012 41, 052 10,504 0 356, 568 10 00 11.00 01100 CAFETERI A 1, 564, 184 49, 767 20, 159 0 1, 634, 110 11.00 01300 NURSING ADMINISTRATION 43, 071 380, 055 2, 340, 827 13.00 1, 747, 361 170, 340 13.00 01500 PHARMACY 25, 231 15.00 15.00 2, 032, 534 427, 268 2, 485, 033 01600 MEDICAL RECORDS & LIBRARY 19, 299 16.00 1.881 8.015 29, 195 16.00 23.00 02300 ALLIED HEALTH-RAD TECH PROGRAM 319, 589 7,067 75, 700 402, 356 23.00 INPATIENT ROUTINE SERVICE COST CENTERS 1, 358, 303 30.00 03000 ADULTS & PEDLATRICS 6. 382. 847 232, 225 142.849 8, 116, 224 30.00 31.00 03100 INTENSIVE CARE UNIT 1, 475, 943 44, 451 17, 911 308, 960 1,847,265 31 00 41.00 04100 SUBPROVI DER - I RF 1, 143, 711 107, 011 566 248, 302 1, 499, 590 41.00 43.00 04300 NURSERY 525, 402 12, 690 17, 433 106, 802 662, 327 43.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 6, 016, 579 257, 503 339, 925 910, 811 7, 524, 818 50 00 05200 DELIVERY ROOM & LABOR ROOM 1, 591, 929 52, 822 323, 606 1, 994, 100 52.00 52.00 25, 743 2, 390, 917 54.00 05400 RADI OLOGY-DI AGNOSTI C 187, 876 392, 069 327, 151 3, 298, 013 54.00 54.01 03630 ULTRA SOUND 388, 945 7, 968 79, 141 476, 054 54.01 56.00 05600 RADI OI SOTOPE 1,086,865 15, 774 26,035 179, 214 1, 307, 888 56.00 05700 CT SCAN 57.00 440,024 1, 902 95, 688 537, 614 57.00 58.00 05800 MAGNETIC RESONANCE I MAGING (MRI) 330, 418 C 73, 309 403, 727 58.00 05900 CARDIAC CATHETERIZATION 59.00 150, 984 3, 155 16, 222 17, 204 187, 565 59 00 06000 LABORATORY 5, 646, 497 3, 103 5, 711, 907 60.00 62, 307 60.00 65.00 06500 RESPIRATORY THERAPY 1, 410, 256 9, 756 54, 011 287, 126 1, 761, 149 65.00 2, 579, 895 06600 PHYSI CAL THERAPY 38 008 529. 747 3, 204, 555 66.00 56, 905 66,00 06700 OCCUPATI ONAL THERAPY 67.00 945, 342 24, 418 13, 588 189, 394 1, 172, 742 67.00 06800 SPEECH PATHOLOGY 235, 646 47, 211 294, 446 68.00 8, 202 3, 387 68.00 06900 ELECTROCARDI OLOGY 758, 832 149, 871 161, 438 1, 101, 713 69.00 69.00 31, 572 07000 ELECTROENCEPHALOGRAPHY 21, 516 25, 080 593, 688 98, 736 739, 020 70.00 70.00 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 1, 536, 861 33, 985 80,077 68, 747 1, 719, 670 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 2, 926, 467 2, 926, 467 72.00 15, 887, 111 07300 DRUGS CHARGED TO PATIENTS 0 0 73 00 15, 887, 111 Ω 73 00 07400 RENAL DIALYSIS 74.00 276,082 C 0 276, 082 74.00 36, 209 76.00 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES 1, 227, 997 0 326, 201 1, 590, 407 76.00 03190 CHEMOTHERAPY 76. 01 4, 962, 246 0 117, 479 5, 079, 725 76.01 03330 ENDOSCOPY 211 703 79, 162 22 537 76 02 313, 402 76 02 76.03 03950 WOUND CARE CENTER 801, 986 23, 661 7,652 55, 204 888, 503 76.03 OUTPATIENT SERVICE COST CENTERS 91.00 09100 EMERGENCY 2, 185, 784 152, 535 72, 278 463, 085 2, 873, 682 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 92.00 Ω 92.00 OTHER REIMBURSABLE COST CENTERS 09500 AMBULANCE SERVICES 95.00 921, 677 31, 296 139, 679 190, 296 1, 282, 948 95.00 SPECIAL PURPOSE COST CENTERS 113.00 11300 INTEREST EXPENSE 113.00 118.00 SUBTOTALS (SUM OF LINES 1 through 117) 119, 992, 059 2, 443, 328 2, 055, 971 8, 648, 673 119, 714, 455 118. 00 NONREI MBURSABLE COST CENTERS 8, 116 190.00 190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 8, 116 0 191. 00 19100 RESEARCH 0 191.00 192.00 19200 PHYSICIANS' PRIVATE OFFICES 1, 976, 329 17, 890 2, 167, 869 192. 00 161, 139 12, 511 192. 01 19201 MARKETI NG 598, 981 598, 981 192. 01 C 0 192. 02 19202 EDUCATION CENTER 20, 716 192. 02 20, 716 0 0 C 193. 00 19300 NONPALD WORKERS 0 0 0 193.00 0 C 194. 00 07950 FOUNDATI ON 1, 517 194. 00 0 1,420 97 0 194. 01 07951 ASPR BI OTERRORI SM GRANT 8, 460 194. 01 8.460 0 C 75, 820 448, 197 194. 02 194. 02 07952 CLINIC OF HOPE 371, 766 C 611 200.00 Cross Foot Adjustments 0 200.00 201.00 Negative Cost Centers 0 201.00

122, 968, 311

2, 069, 190

2, 614, 003

8, 742, 383

122, 968, 311 202. 00

TOTAL (sum lines 118 through 201)

202.00

Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS Provider CCN: 15-0010

				10	06/30/2018	11/26/2018 12	
	Cost Center Description	ADMI NI STRATI VE		LAUNDRY &	HOUSEKEEPI NG	DI ETARY	, , , , , , , , , , , , , , , , , , ,
		& GENERAL	PLANT	LINEN SERVICE	0.00	10.00	
	GENERAL SERVICE COST CENTERS	5. 00	7. 00	8. 00	9. 00	10. 00	
1.00	00100 CAP REL COSTS-BLDG & FIXT				I		1.00
2.00	00200 CAP REL COSTS-MVBLE EQUIP						2. 00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4. 00
5.00	00500 ADMINISTRATIVE & GENERAL	30, 927, 460					5. 00
7.00	00700 OPERATION OF PLANT	1, 562, 545	6, 212, 714				7. 00
8.00	00800 LAUNDRY & LINEN SERVICE	172, 634	14, 463		0.540.007		8. 00
9.00	00900 HOUSEKEEPI NG	569, 975	56, 261		2, 540, 337	(21 712	9.00
10. 00 11. 00	01000 DI ETARY 01100 CAFETERI A	119, 814 549, 092	145, 330 176, 183		0	621, 712 0	10. 00 11. 00
13. 00	01300 NURSING ADMINISTRATION	786, 562	152, 478		1, 945	0	13.00
15. 00	01500 PHARMACY	835, 018	89, 320		1, 710	0	15. 00
16. 00	01600 MEDICAL RECORDS & LIBRARY	9, 810	68, 323		648	0	16. 00
23.00	02300 ALLIED HEALTH-RAD TECH PROGRAM	135, 199	25, 017		0	0	23. 00
	INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00	03000 ADULTS & PEDI ATRI CS	2, 727, 205	822, 111		795, 439	411, 739	30. 00
31. 00	03100 I NTENSI VE CARE UNI T	620, 716	157, 364		194, 513	50, 588	
41. 00	04100 SUBPROVI DER - I RF	503, 891	378, 835		194, 513	99, 026	•
43. 00	04300 NURSERY ANCI LLARY SERVI CE COST CENTERS	222, 554	44, 925	9, 266	107, 008	60, 359	43. 00
50. 00	05000 OPERATING ROOM	2, 528, 482	911, 599	7, 098	389, 026	0	50.00
52. 00	05200 DELIVERY ROOM & LABOR ROOM	670, 055	91, 135		206, 274	0	
54. 00	05400 RADI OLOGY-DI AGNOSTI C	1, 108, 195	665, 110		39, 551	0	54.00
54. 01	03630 ULTRA SOUND	159, 963	0		8, 429	0	54. 01
56.00	05600 RADI OI SOTOPE	439, 475	55, 842	0	29, 177	0	56. 00
57. 00	05700 CT SCAN	180, 649	0		0	0	57. 00
58. 00	05800 MAGNETIC RESONANCE IMAGING (MRI)	135, 660	0		0	0	58. 00
59. 00	05900 CARDI AC CATHETERI ZATI ON	63, 025	11, 168		12, 968	0	59. 00
60. 00 65. 00	06000 LABORATORY 06500 RESPI RATORY THERAPY	1, 919, 309	220, 577		80, 399 3, 890	0	60. 00 65. 00
66. 00	06600 PHYSI CAL THERAPY	591, 780 1, 076, 791	34, 539 201, 451		3, 890 8, 961	0	66.00
67. 00	06700 OCCUPATI ONAL THERAPY	394, 064	86, 444		4, 500	0	67.00
68. 00	06800 SPEECH PATHOLOGY	98, 939	29, 038		9, 233	0	68. 00
69. 00	06900 ELECTROCARDI OLOGY	370, 197	111, 768		5, 187	0	69. 00
70.00	07000 ELECTROENCEPHALOGRAPHY	248, 325	76, 169	0	33, 067	0	70. 00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	577, 842	120, 312	15, 827	72, 618	0	71. 00
72. 00	07200 I MPL. DEV. CHARGED TO PATIENTS	983, 349	0		0	0	72. 00
73. 00	07300 DRUGS CHARGED TO PATIENTS	5, 338, 357	0		29, 177	0	73.00
74. 00 76. 00	07400 RENAL DIALYSIS	92, 769	120, 104	_	12, 968 25, 935	0	74. 00 76. 00
76. 00 76. 01	03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES 03190 CHEMOTHERAPY	534, 407 1, 706, 884	128, 186 0		25, 935	0	76. 00
76. 01	03330 ENDOSCOPY	105, 309	0		0	0	76. 01
76. 03	03950 WOUND CARE CENTER	298, 554	83, 764	-	41, 496	0	76. 03
	OUTPATIENT SERVICE COST CENTERS		·				
91.00	09100 EMERGENCY	965, 612	539, 996	85, 278	233, 415	0	91. 00
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART)						92. 00
	OTHER REIMBURSABLE COST CENTERS	101 005	440 704	0.05/	اه		
95.00	09500 AMBULANCE SERVICES	431, 095	110, 791	9, 256	0	0	95. 00
112 00	SPECIAL PURPOSE COST CENTERS 11300 NTEREST EXPENSE			I	I		113. 00
118.00		29, 834, 102	5, 608, 499	700, 861	2, 540, 337	621, 712	
110.00	NONREI MBURSABLE COST CENTERS	27, 034, 102	3, 000, 477	700,001	2, 340, 337	021, 712	1110.00
190.00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	2,727	28, 731	0	0	0	190. 00
	19100 RESEARCH	0	0		О		191. 00
	19200 PHYSICIANS' PRIVATE OFFICES	728, 445	570, 458	0	0		192. 00
	19201 MARKETI NG	201, 269	0		0		192. 01
	19202 EDUCATION CENTER	6, 961	0	0	0		192. 02
	19300 NONPAL D WORKERS	0	0	0	0		193.00
	07950 FOUNDATION 07951 ASPR BIOTERRORISM GRANT	510	5, 026		0		194. 00 194. 01
	207952 CLINIC OF HOPE	2, 843 150, 603	0		0		194. 01
200.00		130,003	0		٩	O	200. 00
201.00		О	0	o	ol	0	201. 00
202.00		30, 927, 460	6, 212, 714	700, 861	2, 540, 337	621, 712	202. 00

Provider CCN: 15-0010

				To	06/30/2018	Date/Time Pre 11/26/2018 12	
	Cost Center Description	CAFETERI A	NURSI NG ADMI NI STRATI ON	PHARMACY	MEDICAL RECORDS &	ALLI ED HEALTH-RAD	
		11. 00	13. 00	15.00	16. 00	TECH PROGRAM 23.00	
	GENERAL SERVICE COST CENTERS	11.00	13.00	15.00	10.00	23.00	
1.00	00100 CAP REL COSTS-BLDG & FIXT						1. 00
2.00	00200 CAP REL COSTS-MVBLE EQUIP						2. 00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4. 00
5.00	00500 ADMINISTRATIVE & GENERAL						5.00
7. 00 8. 00	00700 OPERATION OF PLANT 00800 LAUNDRY & LINEN SERVICE						7. 00 8. 00
9. 00	00900 HOUSEKEEPING						9. 00
10. 00	01000 DI ETARY						10.00
11. 00	01100 CAFETERI A	2, 359, 385					11. 00
13.00	01300 NURSING ADMINISTRATION	99, 242	3, 381, 054				13. 00
15. 00	01500 PHARMACY	97, 037	0	3, 506, 408	407.07/		15.00
16.00	01600 MEDI CAL RECORDS & LI BRARY	0	0	0	107, 976	E0E 200	16.00
23. 00	02300 ALLIED HEALTH-RAD TECH PROGRAM INPATIENT ROUTINE SERVICE COST CENTERS	22, 717	U	U	0	585, 289	23. 00
30. 00	03000 ADULTS & PEDI ATRI CS	457, 096	1, 218, 125	0	6, 112	0	30.00
31.00	03100 INTENSIVE CARE UNIT	89, 412	238, 275	0	1, 491	0	
41. 00	04100 SUBPROVI DER - I RF	82, 818		0	1, 253	0	41.00
43. 00	04300 NURSERY	32, 800	87, 409	0	835	0	43. 00
50. 00	ANCILLARY SERVICE COST CENTERS O5000 OPERATING ROOM	290, 039	772, 931	0	17, 843	0	50.00
52. 00	05200 DELIVERY ROOM & LABOR ROOM	99, 382	264, 845	0	2, 802	0	52. 00
54. 00	05400 RADI OLOGY-DI AGNOSTI C	112, 748	0	0	5, 094	218, 444	
54. 01	03630 ULTRA SOUND	18, 802	0	0	1, 706	73, 190	
56. 00	05600 RADI OI SOTOPE	44, 543	0	0	4, 015	172, 193	56. 00
57. 00	05700 CT SCAN	24, 730	0	0	2, 223	95, 322	
58. 00	05800 MAGNETIC RESONANCE I MAGING (MRI)	21, 688	12 202	0	609	26, 140	
59. 00 60. 00	05900 CARDI AC CATHETERI ZATI ON 06000 LABORATORY	4, 609 0	12, 283 0	0	372 14, 246	0	59. 00 60. 00
65. 00	06500 RESPIRATORY THERAPY	85, 760	0	0	2, 523	0	65.00
66. 00	06600 PHYSI CAL THERAPY	155, 901	0	Ō	2, 892	0	66. 00
67.00	06700 OCCUPATI ONAL THERAPY	55, 736	0	0	955	0	67. 00
68. 00	06800 SPEECH PATHOLOGY	13, 893	0	0	211	0	68. 00
69.00	06900 ELECTROCARDI OLOGY	49, 184	0	0	3, 040	0	69.00
70. 00 71. 00	07000 ELECTROENCEPHALOGRAPHY 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	33, 661 33, 848	0	0	1, 403 3, 087	0	70. 00 71. 00
71.00	07200 I MPL. DEV. CHARGED TO PATIENTS	33, 646 0	0	0	2, 699	0	72.00
73. 00	07300 DRUGS CHARGED TO PATIENTS	0	o	3, 503, 246	11, 920	0	73. 00
74.00	07400 RENAL DIALYSIS	0	0	0	52	0	74. 00
76. 00	03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	105, 938	0	0	1, 116	0	76. 00
76. 01	03190 CHEMOTHERAPY	42, 521	113, 315	0	1, 044	0	76. 01
76. 02 76. 03	03330 ENDOSCOPY 03950 WOUND CARE CENTER	5, 422 21, 436	14, 449 57, 126	0	629 2, 970	0	76. 02 76. 03
70.03	OUTPATIENT SERVICE COST CENTERS	21, 430	37, 120	٥	2, 770	0	70.03
91. 00	09100 EMERGENCY	143, 191	381, 593	0	13, 077	0	
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)						92.00
05 00	OTHER REIMBURSABLE COST CENTERS O9500 AMBULANCE SERVICES	90, 108	0	0	1, 757	0	95. 00
93.00	SPECIAL PURPOSE COST CENTERS	90, 106	U	U _I	1, 737	U	95.00
113.00	11300 NTEREST EXPENSE						113. 00
118.00		2, 334, 262	3, 381, 054	3, 503, 246	107, 976	585, 289	118. 00
100.00	NONREI MBURSABLE COST CENTERS	0	٥				100 00
	1900 GIFT, FLOWER, COFFEE SHOP & CANTEEN 1910 RESEARCH	0	0	0	0		190. 00 191. 00
	19200 PHYSICIANS' PRIVATE OFFICES	3, 731	0	0	0		192. 00
	19201 MARKETI NG	0	0	Ō	0		192. 01
	19202 EDUCATION CENTER	0	0	0	0		192. 02
	19300 NONPALD WORKERS	0	0	0	0		193. 00
	07950 FOUNDATION 07951 ASPR BIOTERRORISM GRANT	0	0	0	0		194. 00
	07951 ASPR BIOTERRORISM GRANT 07952 CLINIC OF HOPE	0 21, 392	0	3, 162	O O		194. 01 194. 02
200.00		21, 372		3, 102			200. 00
201.00		0	o	0	o	0	201. 00
202.00	TOTAL (sum lines 118 through 201)	2, 359, 385	3, 381, 054	3, 506, 408	107, 976		

Provider CCN: 15-0010

| Peri od: | Worksheet B | From 07/01/2017 | Part | To 06/30/2018 | Date/Time Prepared: | 12/02/2019 | 12/02/2019 | 12/02/2019 | 12/02/2019 | 12/02/2019 | 12/02/2019 | 12/02/2019 | 12/02/2019 | 12/02/2019 | 12/02/2019 | 12/02/2019 | 12/02/2019 | 12/02/2019 | 12/02/2019 | 12/02/2019 | 12/02/2019 | 12/02/2019 | 12/02/2019 | 12/02/2019 | 12/02/2019 | 12/02/2019 | 12/02/2019 | 12/02/2019 | 12/02/2019 | 12/02/2019 | 12/02/2019 | 12/02/2019 | 12/02/2019 | 12/02/2019 | 12/02/2019 | 12/02/2019 | 12/02/2019 | 12/02/2019 | 12/02/2019 | 12/02/2019 | 12/02/2019 | 12/02/2019 | 12/02/2019 | 12/02/2019 | 12/02/2019 | 12/02/2019 | 12/02/2019 | 12/02/2019 | 12/02/2019 | 12/02/2019 | 12/02/2019 | 12/02/2019 | 12/02/2019 | 12/02/2019 | 12/02/2019 | 12/02/2019 | 12/02/2019 | 12/02/2019 | 12/02/2019 | 12/02/2019 | 12/02/2019 | 12/02/2019 | 12/02/2019 | 12/02/2019 | 12/02/2019 | 12/02/2019 | 12/02/2019 | 12/02/2019 | 12/02/2019 | 12/02/2019 | 12/02/2019 | 12/02/2019 | 12/02/2019 | 12/02/2019 | 12/02/2019 | 12/02/2019 | 12/02/2019 | 12/02/2019 | 12/02/2019 | 12/02/2019 | 12/02/2019 | 12/02/2019 | 12/02/2019 | 12/02/2019 | 12/02/2019 | 12/02/2019 | 12/02/2019 | 12/02/2019 | 12/02/2019 | 12/02/2019 | 12/02/2019 | 12/02/2019 | 12/02/2019 | 12/02/2019 | 12/02/2019 | 12/02/2019 | 12/02/2019 | 12/02/2019 | 12/02/2019 | 12/02/2019 | 12/02/2019 | 12/02/2019 | 12/02/2019 | 12/02/2019 | 12/02/2019 | 12/02/2019 | 12/02/2019 | 12/02/2019 | 12/02/2019 | 12/02/2019 | 12/02/2019 | 12/02/2019 | 12/02/2019 | 12/02/2019 | 12/02/2019 | 12/02/2019 | 12/02/2019 | 12/02/2019 | 12/02/2019 | 12/02/2019 | 12/02/2019 | 12/02/2019 | 12/02/2019 | 12/02/2019 | 12/02/2019 | 12/02/2019 | 12/02/2019 | 12/02/2019 | 12/02/2019 | 12/02/2019 | 12/02/2019 | 12/02/2019 | 12/02/2019 | 12/02/2019 | 12/02/2019 | 12/02/2019 | 12/02/2019 | 12/02/2019 | 12/02/2019 | 12/02/2019 | 12/02/2019 | 12/02/2019 | 12/02/2019 | 12/02/2019 | 12/02/2019 | 12/02/2019 | 12/02/2019 | 12/02/2019 | 12/02/2019 | 12/02/2019 | 12/02/2019 | 12/02/2019 | 12/02/2019 | 12/02/2019 | 12/02/2019 | 12/02/

			To	o 06/30/2018 Date/Time I 11/26/2018	
Cost Center Description	Subtotal	Intern &	Total	1172072010	12.03 piii
		Residents Cost			
		& Post			
		Stepdown Adjustments			
	24. 00	25. 00	26. 00		
GENERAL SERVICE COST CENTERS					
1.00 00100 CAP REL COSTS-BLDG & FIXT					1.00
2. 00 00200 CAP REL COSTS-MVBLE EQUI P					2.00
4.00 00400 EMPLOYEE BENEFITS DEPARTMENT 5.00 00500 ADMINISTRATIVE & GENERAL					4. 00 5. 00
7. 00 00700 OPERATION OF PLANT					7. 00
8.00 00800 LAUNDRY & LINEN SERVICE					8. 00
9. 00 00900 HOUSEKEEPI NG					9. 00
10. 00 01000 DI ETARY					10.00
11. 00 01100 CAFETERI A					11.00
13. 00 01300 NURSI NG ADMI NI STRATI ON 15. 00 01500 PHARMACY					13. 00 15. 00
16. 00 01600 MEDICAL RECORDS & LIBRARY					16.00
23.00 02300 ALLIED HEALTH-RAD TECH PROGRAM					23. 00
INPATIENT ROUTINE SERVICE COST CENTERS					
30. 00 03000 ADULTS & PEDI ATRI CS	14, 780, 623	0	14, 780, 623		30.00
31.00 03100 INTENSIVE CARE UNIT 41.00 04100 SUBPROVIDER - IRF	3, 254, 991	0	3, 254, 991 3, 002, 694		31. 00 41. 00
41. 00 04100 SUBPROVI DER - TRF 43. 00 04300 NURSERY	3, 002, 694 1, 227, 483	0	1, 227, 483		43.00
ANCI LLARY SERVI CE COST CENTERS	1,221,403	<u> </u>	1, 227, 403		43.00
50. 00 05000 OPERATING ROOM	12, 441, 836	0	12, 441, 836		50. 00
52.00 05200 DELIVERY ROOM & LABOR ROOM	3, 353, 713	0	3, 353, 713		52. 00
54. 00 05400 RADI OLOGY - DI AGNOSTI C	5, 462, 848	0	5, 462, 848		54.00
54. 01 03630 ULTRA SOUND 56. 00 05600 RADI OI SOTOPE	741, 029 2, 053, 133	0	741, 029 2, 053, 133		54. 01 56. 00
57. 00 05700 CT SCAN	846, 191	0	846, 191		57.00
58. 00 05800 MAGNETIC RESONANCE IMAGING (MRI)	589, 187	o	589, 187		58. 00
59. 00 05900 CARDIAC CATHETERIZATION	291, 990	0	291, 990		59. 00
60. 00 06000 LABORATORY	7, 946, 961	0	7, 946, 961		60. 00
65. 00 06500 RESPIRATORY THERAPY	2, 480, 122	0	2, 480, 122		65.00
66. 00 06600 PHYSI CAL THERAPY 67. 00 06700 OCCUPATI ONAL THERAPY	4, 650, 551 1, 714, 441	0	4, 650, 551 1, 714, 441		66. 00 67. 00
68. 00 06800 SPEECH PATHOLOGY	446, 204		446, 204		68. 00
69. 00 06900 ELECTROCARDI OLOGY	1, 641, 089	O	1, 641, 089		69. 00
70. 00 07000 ELECTROENCEPHALOGRAPHY	1, 131, 645	0	1, 131, 645		70. 00
71. 00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS	2, 543, 204	0	2, 543, 204		71.00
72.00 O7200 IMPL. DEV. CHARGED TO PATIENTS 73.00 O7300 DRUGS CHARGED TO PATIENTS	3, 912, 564 24, 769, 890	0	3, 912, 564		72. 00 73. 00
74. 00 07400 RENAL DI ALYSI S	381, 871	0	24, 769, 890 381, 871		74.00
76. 00 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	2, 385, 989	o	2, 385, 989		76. 00
76. 01 03190 CHEMOTHERAPY	6, 943, 489	0	6, 943, 489		76. 01
76. 02 03330 ENDOSCOPY	439, 211	0	439, 211		76. 02
76. 03 03950 WOUND CARE CENTER OUTPATIENT SERVICE COST CENTERS	1, 393, 849	0	1, 393, 849		76. 03
91. 00 09100 EMERGENCY	5, 235, 844	O	5, 235, 844		91. 00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	1, 200, 011	0	2, 222, 211		92. 00
OTHER REIMBURSABLE COST CENTERS					
95. 00 09500 AMBULANCE SERVI CES	1, 925, 955	0	1, 925, 955		95. 00
SPECIAL PURPOSE COST CENTERS 113. 00 11300 NTEREST EXPENSE	1				113. 00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	117, 988, 597	0	117, 988, 597		118.00
NONREI MBURSABLE COST CENTERS			,,		
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	39, 574	0	39, 574		190. 00
191. 00 19100 RESEARCH	0	0	0		191. 00
192.00 19200 PHYSICIANS' PRIVATE OFFICES 192.01 19201 MARKETING	3, 470, 503 800, 250	0	3, 470, 503 800, 250		192. 00 192. 01
192. 02 19202 EDUCATION CENTER	27, 677	0	27, 677		192. 01
193. 00 19300 NONPALD WORKERS	0		27, 377		193. 00
194. 00 07950 FOUNDATI ON	7, 053	0	7, 053		194. 00
194. 01 07951 ASPR BI OTERRORI SM GRANT	11, 303	0	11, 303		194. 01
194. 02 07952 CLINIC OF HOPE	623, 354		623, 354		194. 02
200.00 Cross Foot Adjustments 201.00 Negative Cost Centers	0	0	0		200. 00 201. 00
202.00 TOTAL (sum lines 118 through 201)	122, 968, 311	-	122, 968, 311		201.00
, , , , , , , , , , , , , , , , , , , ,		, -1			

Heal th Financial Systems

ST. JOSEPH HOSPITAL & HEALTH CENTER

In Lieu of Form CMS-2552-10

Provider CCN: 15-0010

Period:
From 07/01/2017
To 06/30/2018

Part II
Date/Time Prepared:
11/26/2018 12: 03 pm

CAPITAL RELATED COSTS

Cost Center Description

Directly
Assigned New
Capital

Capital

DEPARTMENT

Cost Center Description					CAPI TAL REI	ATED COSTS			•
CENERAL SERVICE COST CENTERS CONTROL CON			Cost Center Description	Directly	RIDG & FLYT	MVRLE FOLLE	Subtotal	EMPLOYEE	
Related Costs			cost center bescription		DEDG & TTAT	WVDLL LQ011	Subtotal		
CENERAL SERVICE COST CENTERS 1.00 2.00 2A 4.00 1.00								DEPARTMENT	
GENERAL SERVICE COST CENTERS					1.00	2.00	2.4	4.00	
1.00		GENER	AL SERVICE COST CENTERS	U	1.00	2.00	ZA	4.00	
0.0400 EMPLOYEE BENEFITS DEPARTMENT 0 101.1111 245 101.356 101.356 4.00	1. 00								1.00
0.0000 0.0000 ADM IN STRATIVE & GENERAL 2, 108, 423 399, 240 8, 195 2, 511, 858 12, 850 5, 00	2.00	00200	CAP REL COSTS-MVBLE EQUIP						2. 00
7. 00 00000 (OPERATION OF PLANT) 0 362,723 151,077 513,800 832 7. 00 9. 00 00900 LAUNDRY & LINEN SERVICE 0 4,085 0 4,085 0 9. 00 10. 00 01000 DI CHARY 0 14,052 1. 05,04 15,556 0 10. 00 11. 00 01100 CAFETERI A 0 44,767 20,159 69,926 0 11. 00 15. 00 01100 CAFETERI A 0 49,767 20,159 69,926 0 11. 00 15. 00 01500 PHARMACY 0 25,231 7. 067 878 15. 00 23. 00 01500 PHARMACY 0 19,299 8,015 27,314 0 16.00 30. 00 03000 ALLIED HEALTH-RAD TECH PROGRAM 0 7,067 0 7. 067 878 23. 00 30. 00 03000 JAULTES & PEDIATRICS 0 232,225 142,849 375,074 15,738 30. 00 4000 JERATIK IN CARE LINES SERVICE COST CENTERS 0 122,690				0					
0.000 0.0000 LAINDRY & LINEN SERVICE 0 4.085 0 4.085 0 9.00				2, 108, 423					
9.00 000000 HOLSEKEEPI NG 0 15,892 5,838 21,730 0 9,00 11.00 01100 DIETARY 0 41,052 10,504 51,556 0 10,00 11.00 01100 CAFETERI A 0 49,767 20,159 69,926 0 11,00 15.00 01500 MURSI NG ADMINISTRATION 0 43,071 70,340 213,411 4,407 13,00 15.00 01500 PHARMACY 0 25,231 0 25,231 4,954 15,00 23.00 10500 MEDICAL RECORDS & LI BRARY 0 79,067 70 7,067 878 23,00 23.00 10200 MEDICAL RECORDS & LI BRARY 0 7,067 70 7,067 878 23,00 23.00 10200 ALUET & FEDRUATE COST CENTERS				0					
10.00 01000 0150				0					
11. 00 01100 CAFTERIA 0 49,767 20,159 69,926 0 11. 00 13. 00 1300 NURSI NG ADMINI STRATI ON 0 25,231 0 25,231 4,954 15,00 15.00 01500 PHARMACY 0 25,231 0 25,231 4,954 15,00 16.00 01600 MEDI CAL RECORDS & LIBRARY 0 19,299 8,015 27,314 0 16.00 16.00 01600 MEDI CAL RECORDS & LIBRARY 0 7,067 0 7,067 878 33.00 NURSI NG ADMINI STRATION 0 10,000 10,		1		0				_	
15.00 01500 PHARMACY 0 25, 231 0 25, 231 4, 954 15.00				0				-	
16. 00 01600 MEDICAL RECORDS & LIBRARY 0 19, 299 8, 015 27, 314 0 16. 00 23. 00 20300 ALLIER HEALTH-RAD TECH PROGRAM 0 7, 067 0 7, 067 878 23. 00 20300 ALLIER HEALTH-RAD TECH PROGRAM 0 7, 067 0 7, 067 10. 00 3000 ADULTS & PEDIATRICS 0 232, 225 142, 849 375, 074 15, 738 30. 00 10. 00 3100 0100 INTENSI VE CARE UNIT 0 44, 451 17, 911 62, 362 3, 582 31. 00 11. 00 04100 SUBPROVI DER - I RF 0 107, 011 566 107, 577 2, 879 41. 00 12. 00 04100 SUBPROVI DER - I RF 0 107, 011 566 107, 577 2, 879 41. 00 13. 00 04300 NURSERY 0 12, 640 17, 433 30. 123 1, 238 14. 00 04100 SUBPROVI DER - I RF 0 12, 640 17, 433 30. 123 1, 238 14. 00 04100 SUBPROVI DER - I RF 0 12, 640 17, 433 30. 123 1, 238 14. 00 04100 SUBPROVI DER - I RF 0 12, 640 17, 433 30. 123 1, 238 15. 00 0500 ODERATI NO ROOM 0 25, 7503 339, 925 597, 428 10, 561 50. 00 15. 00 0500 ODERATI NO ROOM 0 25, 743 52, 822 78, 565 3, 752 52. 00 15. 00 0500 ODERATI NO ROOM 0 0 0 7, 668 7, 968 79, 845 3, 793 54. 00 15. 00 0500 ODERATI NO ROOM 0 0 0 7, 668 7, 968 79, 845 54. 01 15. 00 05600 RADIO LICRY-DI AGNOSTI C 0 15, 774 26, 035 41, 809 2, 078 56. 00 15. 00 05600 RADIO LICRY-DI AGNOSTI C 0 15, 774 26, 035 41, 809 2, 078 56. 00 15. 00 05600 RADIO LICRY-DI AGNOSTI C 0 15, 774 26, 035 41, 809 2, 078 56. 00 15. 00 05600 RADIO LICRY-DI AGNOSTI C 0 0 0 0 0 0 0 15. 00 05600 RADIO LICRY-DI AGNOSTI C 0 0 0 0 0 0 0 15. 00 05600 RADIO LICRY-DI AGNOSTI C 0 0 0 0 0 0 0 15. 00 05600 RADIO LICRY-DI AGNOSTI C 0 0 0 0 0 0 0 0 15. 00 05600 RADIO LICRY-DI AGNOSTI C 0 0 0 0 0 0 0 0 15. 00 05600 RADIO LICRY-DI AGNOSTI C 0 0 0	13.00	01300	NURSING ADMINISTRATION	0	43, 071	170, 340	213, 411	4, 407	13. 00
10 10 10 10 10 10 10 10		1		0					
INPATI ENT ROUTI NS SERVI CE COST CENTERS 0 232, 225 142, 849 375, 074 15, 738 30, 00 30, 00 3000 ADULTS & PEDI ATRIC S 0 444, 451 17, 911 62, 362 3, 582 31, 00 410, 00 410, 00 410, 00 444, 451 17, 911 62, 362 3, 582 31, 00 410, 00 41				0					
30.00 03000 ADULTS & PEDIATRICS 0 232, 225 142, 849 375, 074 15, 738 30.00	23.00			U	7,067	0	7, 067	8/8	23.00
11.00 03100 INTENSIVE CARE LINIT 0 44, 451 17, 911 62, 362 3, 582 31.00	30. 00			0	232, 225	142, 849	375. 074	15, 738	30.00
43.00				Ö					
ANCILLARY SERVICE COST CENTERS 10,500 5000 050	41.00			0	107, 011				
50 00 05000 05000 05000 0520	43.00			0	12, 690	17, 433	30, 123	1, 238	43. 00
S2.00 05200 DELIVERY ROOM & LABOR ROOM 0 25,743 52,822 78,565 3,752 52.00	F0 00				057.500	222 225	507 400	40.5/4	F0 00
54. 00 0 5400 RADI OLOGY - DI AGNOSTI C 0 187, 876 392, 069 579, 945 3, 793 54. 01 54. 01 0 3630 ULTRA SOUND 0 0 7, 968 7, 968 918 54. 01 56. 00 0 5600 RADI OI SOTOPE 0 15, 774 26, 035 41, 809 2, 078 56. 00 57. 00 0 5700 CT SCAN 0 0 1, 902 1, 902 1, 110 57. 00 58. 00 0 5800 MAGNETI C RESONANCE I MAGI NG (MRI) 0 0 0 0 0 850. 58. 00 59. 00 0 5900 CARDI AC CATHETERI ZATI ON 0 3, 155 16, 222 19, 377 199 59. 00 60. 00 0 6500 RESPI RATORY THERAPY 0 62, 307 3, 103 65, 410 0 60.00 65. 00 0 6600 PHYSI CAL THERAPY 0 56, 905 38, 008 94, 913 6, 143 66. 00 67. 00 0 6700 OCCUPATI ONAL THERAPY 0 24, 418 13, 588 38, 006 2, 196 67. 00 68				0					
54. 01 03630 ULTRA SOUND 0 0 7,968 7,968 918 54. 01 56. 00 05600 RABIO IS OSTOPE 0 15,774 26,035 41,809 2,078 56. 00 57. 00 05700 CTS CAN 0 0 1,902 1,902 1,110 57. 00 58. 00 05800 MAGNETIC RESONANCE I MAGING (MRI) 0 0 0 0 850 58.00 59. 00 05900 CARDIA C CATHETERI ZATION 0 3,155 16,222 19,377 199 59. 00 60. 00 06000 LABORATORY 0 62,307 3,103 65,410 0 00. 00 65. 00 06500 RESPI RATORY THERAPY 0 56,905 38,008 94,913 6,143 66. 00 66. 00 06600 PHYSI CAL THERAPY 0 56,905 38,008 94,913 6,143 66. 00 68. 00 08600 SPECEH PATHOLOGY 0 8,202 3,387 11,58				0					
56.00 05600 RADI OI SOTOPE 0 15,774 26,035 41,809 2,078 56.00 57.00 05700 CT SCAN 0 0 0 0 0 0 0 0 0		1		0					
58. 00 0 5800 MAGNETI C RESONANCE I MAGI NG (MRI) 0 0 0 0 0 850 58. 00 59. 00 05900 CARDI AC CATHETERI ZATI ON 0 3, 155 16, 222 19, 377 199 59. 00 0 0. 00 6000 LABORATORY 0 62, 307 3, 103 65, 410 0 60. 00 0 0 0 0 0. 00 0 </td <td>56. 00</td> <td></td> <td></td> <td>0</td> <td>15, 774</td> <td></td> <td></td> <td>2, 078</td> <td>56. 00</td>	56. 00			0	15, 774			2, 078	56. 00
59. 00 05900 CARDI AC CATHETERI ZATI ON 0 3, 155 16, 222 19, 377 199 59. 00 60. 00 06000 LABORATORY 0 62, 307 3, 103 65, 410 0 60. 00 65. 00 06500 RESPI RATORY THERAPY 0 9, 756 54, 011 63, 767 3, 329 65. 00 66. 00 06600 PHYSI CAL THERAPY 0 56, 905 38, 008 94, 913 66. 00 67. 00 06700 OCCUPATI ONAL THERAPY 0 24, 418 13, 588 38, 006 2, 196 67. 00 68. 00 06800 SPEECH PATHOLOGY 0 8, 202 3, 387 11, 589 547 68. 00 69. 00 06900 ELECTROCARDI OLOGY 0 31, 572 149, 871 181, 443 1, 872 69. 00 70. 00 07000 ELECTROENCEPHALOGRAPHY 0 21, 516 25, 080 46, 596 1, 145 70. 00 71. 00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS 0 33, 985 80, 077 114, 062 797 71. 00		1	l e e e e e e e e e e e e e e e e e e e	0					
60. 00 06000 LABORATORY 0 62, 307 3, 103 65, 410 0 60. 00 65. 00 06500 RESPI RATORY THERAPY 0 9, 756 54, 011 63, 767 3, 329 65. 00 66. 00 06600 PHYSI CAL THERAPY 0 56, 905 38, 008 94, 913 61, 143 66. 00 67. 00 06700 OCCUPATI ONAL THERAPY 0 24, 418 13, 588 38, 006 2, 196 67. 00 68. 00 06800 SPEECH PATHOLOGY 0 8, 202 3, 387 11, 589 547 68. 00 69. 00 06900 ELECTROCARDI OLOGY 0 31, 572 149, 871 181, 443 1, 872 69. 00 70. 00 07000 ELECTROCEPHALOGRAPHY 0 21, 516 25, 080 46, 596 1, 145 70. 00 71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS 0 33, 985 80, 077 114, 062 797 71. 00 72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 0 0 0 0 0 74. 00 07400 RENAL DI ALYSI S 0 0 0 0 0 74. 00 07400 RENAL DI ALYSI S 0 0 0 0 0 76. 01 03190 CHEMOTHERAPY 0 23, 661 7, 652 31, 313 640 76. 01 03330 ENDOSCOPY 0 23, 661 7, 652 31, 313 640 76. 02 03350 MOUND CARE CENTER 0 23, 661 7, 652 31, 313 640 76. 03 09200 DEBSERVATI ON BEDS (NON-DI STI NCT PART) 0 00 00 00 EMERGENCY 0 0				0			- 1		
65. 00 06500 RESPIRATORY THERAPY 0 9,756 54,011 63,767 3,329 65.00 66. 00 06600 PHYSI CAL THERAPY 0 56,905 38,008 94,913 6,143 66.00 67. 00 06700 0CCUPATI ONAL THERAPY 0 24,418 13,588 38,006 2,196 67.00 68. 00 06800 SPEECH PATHOLOGY 0 8,202 3,387 11,589 547 68.00 69. 00 06900 ELECTROCARDI OLOGY 0 31,572 149,871 181,443 1,872 69.00 70. 00 07000 ELECTROENCEPHALOGRAPHY 0 21,516 25,080 46,596 1,145 70.00 71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS 0 33,985 80,077 114,062 797 71.00 73. 00 07300 DRUGS CHARGED TO PATIENTS 0 0 0 0 0 0 74. 00 07400 RENAL DI ALYSI S 0 0 0 0 0 0 76. 00 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES 0 36,209 0 36,209 3,782 76.01 76. 01 03190 CHEMOTHERAPY 0 0 0 0 0 0 76. 02 03330 ENDOSCOPY 0 0 0 0 0 76. 03 03950 WOUND CARE CENTER 0 23,661 7,652 31,313 640 76. 04 09200 DSERVATI ON BEDS (NON-DI STI NCT PART) 0 79. 00 09200 DSERVATI ON BEDS (NON-DI STI NCT PART) 0 79. 00 00 00 00 00 00 70. 00 00 00 00 00 70. 00 00 00 00 70. 00 00 00 00 70. 00 00 00 00 70. 00 00 00 00 70. 00 00 00 70. 00 00 00 00 70. 00 00				0					
66. 00 06600 PHYSI CAL THERAPY 0 56, 905 38, 008 94, 913 6, 143 66. 00 67. 00 06700 0CCUPATI ONAL THERAPY 0 24, 418 13, 588 38, 006 2, 196 67. 00 68. 00 06800 SPEECH PATHOLOGY 0 8, 202 3, 387 11, 589 547 68. 00 69. 00 6				0					
67. 00 06700 OCCUPATI ONAL THERAPY 0 24, 418 13, 588 38, 006 2, 196 67. 00 68. 00 06800 SPECH PATHOLOGY 0 8, 202 3, 387 11, 589 547 68. 00 69. 00 6900 ELECTROCARDI OLOGY 0 31, 572 149, 871 181, 443 1, 872 69. 00 70. 00 7000 ELECTROENCEPHALOGRAPHY 0 21, 516 25, 080 46, 596 1, 145 70. 00 7100 MEDI CAL SUPPLIES CHARGED TO PATI ENTS 0 33, 985 80, 077 114, 062 797 71. 00 72. 00 7200 IMPL. DEV. CHARGED TO PATI ENTS 0 0 0 0 0 0 0 72. 00 73. 00 07300 DRUGS CHARGED TO PATI ENTS 0 0 0 0 0 0 0 0 73. 00 74. 00 74. 00 07400 RENAL DI ALYSIS 0 0 0 0 0 0 0 0 0 74. 00 76. 00 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES 0 36, 209 0 36, 209 3, 782 76. 00 76. 01 03190 CHEMOTHERAPY 0 0 0 0 79, 162 79, 162 261 76. 01 76. 02 03330 ENDOSCOPY 0 0 23, 661 7, 652 31, 313 640 76. 03 03950 WOUND CARE CENTER 0 23, 661 7, 652 31, 313 640 76. 03 07400 EMERGENCY 0 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART) 0 07100 EMERGENCY 0 000 DEMERGENCY				0					
69. 00	67. 00	06700	OCCUPATIONAL THERAPY	0					
70. 00 07000 ELECTROENCEPHALOGRAPHY 0 21, 516 25, 080 46, 596 1, 145 70. 00 71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENTS 0 33, 985 80, 077 114, 062 797 71. 00 72. 00 72. 00 73. 00 07200 MPL. DEV. CHARGED TO PATI ENTS 0 0 0 0 0 0 0 72. 00 73. 00 07300 DRUGS CHARGED TO PATI ENTS 0 0 0 0 0 0 0 0 74. 00 74. 00 07400 RENAL DI ALYSI S 0 0 0 0 0 0 0 0 0		1		0					
71. 00				0					
72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 0 0 0 0 0 72. 00 73. 00 07300 DRUGS CHARGED TO PATIENTS 0 0 0 0 0 0 73. 00 74. 00 07400 RENAL DIALYSIS 0 0 0 0 0 0 0 74. 00 76. 00 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES 0 36, 209 0 36, 209 3, 782 76. 01 03190 CHEMOTHERAPY 0 0 0 0 0 1, 362 76. 02 03330 ENDOSCOPY 0 0 79, 162 79, 162 261 76. 02 76. 03 03950 WOUND CARE CENTER 0 23, 661 7, 652 31, 313 640 76. 04 09100 EMERGENCY 0 152, 535 72, 278 224, 813 5, 370 91. 00 09200 OBSERVATI ON BEDS (NON-DI STINCT PART) 0 0 0THER REIMBURSABLE COST CENTERS				0					
73. 00 07300 DRUGS CHARGED TO PATIENTS 0 0 0 0 0 0 73. 00 74. 00 07400 RENAL DI ALYSI S 0 0 0 0 0 0 74. 00 76. 00 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES 0 36, 209 0 36, 209 3, 782 76. 01 03190 CHEMOTHERAPY 0 0 0 0 0 1, 362 76. 02 03330 ENDOSCOPY 0 0 79, 162 76. 03 03950 WOUND CARE CENTER 0 23, 661 7, 652 31, 313 640 76. 04 09100 EMERGENCY 0 152, 535 72, 278 224, 813 5, 370 91. 00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART) 0 0 0THER REI MBURSABLE COST CENTERS				0					
74. 00				o o	_		ĭ	-	
76. 01 03190 CHEMOTHERAPY 0 0 0 0 0 0 1, 362 76. 01 76. 02 03330 ENDOSCOPY 0 0 0 79, 162 79, 162 261 76. 02 76. 03 03950 WOUND CARE CENTER 0 23, 661 7, 652 31, 313 640 76. 03 01 01 01 01 01 01 01 01 01 01 01 01 01				0	0	0	0		
76. 02 03330 ENDOSCOPY 0 0 79, 162 79, 162 261 76. 02 76. 03 03950 WOUND CARE CENTER 0 23, 661 7, 652 31, 313 640 76. 03 04 04 04 04 04 04 04 04 04 04 04 04 04				0	36, 209		36, 209		
76. 03 03950 WOUND CARE CENTER 0 23, 661 7, 652 31, 313 640 76. 03 OUTPATIENT SERVICE COST CENTERS 91. 00 09100 EMERGENCY 0 152, 535 72, 278 224, 813 5, 370 91. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 0 92. 00 OTHER REIMBURSABLE COST CENTERS		1		0	_	-	0		
OUTPATIENT SERVICE COST CENTERS 91. 00 09100 EMERGENCY 0 152, 535 72, 278 224, 813 5, 370 91. 00 92. 00 09200 0BSERVATI ON BEDS (NON-DI STI NCT PART) 0 92. 00 OTHER REI MBURSABLE COST CENTERS 91. 00 92. 00 00 00 00 00 00 00 00		1		0					
91. 00	70.03			U	23,001	7,032	31, 313	040	76.03
92. 00 09200 OBSERVATI ON BEDS (NON-DISTINCT PART) 0 92. 00 OTHER REIMBURSABLE COST CENTERS	91. 00			0	152, 535	72, 278	224, 813	5, 370	91. 00
	92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)				0		92. 00
95 00 109500LAMBULANCE SERVICES 0L 31 296L 139 679L 170 975L 2 207L 95 00				_					
	95. 00			0	31, 296	139, 679	170, 975	2, 207	95. 00
SPECIAL PURPOSE COST CENTERS 113. 00 11300 INTEREST EXPENSE 113. 00	113 00								113 00
118.00 SUBTOTALS (SUM OF LINES 1 through 117) 2, 108, 423 2, 443, 328 2, 055, 971 6, 607, 722 100, 270 118.00		1		2, 108, 423	2, 443, 328	2, 055, 971	6, 607, 722	100, 270	
NONREI MBURSABLE COST CENTERS				27 1007 120	27 1 107 020	2,000,771	0,00,,,22	100/ 270	
190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 8, 116 0 8, 116 0 190. 00	190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	8, 116	0	8, 116		
191. 00 19100 RESEARCH 0 0 0 0 0 191. 00				0	_	-	0		
192. 00 19200 PHYSI CI ANS' PRI VATE OFFI CES 0 161, 139 12, 511 173, 650 207 192. 00				0	161, 139	12, 511	173, 650		
192. 01 19201 MARKETI NG 0 0 0 0 0 192. 01 192. 02 19202 EDUCATI ON CENTER 0 0 0 0 0 0 192. 02				0	0	0	0		
193. 00 19300 NONPAI D WORKERS 0 0 0 0 0 193. 00				0	0	0	0		
194. 00 07950 FOUNDATION 0 1, 420 97 1, 517 0 194. 00		1		0	1, 420	97	1, 517		
194. 01 07951 ASPR BI OTERRORI SM GRANT 0 0 0 0 0 194. 01	194. 01	07951	ASPR BIOTERRORISM GRANT	0	0	0	0	0	194. 01
194. 02 07952 CLI NI C OF HOPE 0 0 611 611 879 194. 02				0	0	611	611	879	
200. 00 Cross Foot Adjustments 0 200. 00		1			_		0	_	
201.00 Negative Cost Centers 0 0 0 0 201.00 202.00 TOTAL (sum lines 118 through 201) 2,108,423 2,614,003 2,069,190 6,791,616 101,356 202.00			, ,	2 100 422	2 614 002	2 060 100	0 6 701 616	101 354	201.00
252. 351 1.5.1.12 (36m 11.105 1.10 (11.106g) 201) 2,100, 720 2,017,000 2,007,170 0,771,010 101,330 202.00	202.00	1	1.5 (Sam 11105 110 till Ough 201)	2, 100, 423	2,014,003	2,009,190	3, 7, 71, 010	101,330	1-02.00

Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS Provider CCN: 15-0010

CARL CATCH DESCRIPTION CONTROL					10	06/30/2018	11/26/2018 12	
Service Serv		Cost Center Description	ADMI NI STRATI VE	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG		, , , , , , , , , , , , , , , , , , ,
SERNING SERVICE COST.CEMPERS 1.00 0.000 CAP REL COSTS-EDLE & FIXT 2.00 0.000 0.000 CAP REL COSTS-EDLE & FIXT 2.00 0.000							10.00	
1.00		CENEDAL SEDVICE COST CENTERS	5.00	7. 00	8.00	9. 00	10.00	
2.00	1 00		I			T		1 00
4 00 00400 DMPLOYEE BENEFITS DEPARTMENT 2,524,708 5.00 00500 DMIN SISTATI ON 2,524,708 7.00 00000 DEPART ON OF PLANT 127,7554 642,186 7.00 7								ł
7.00 0.0700 OPF PANT OF PLANT 127, \$54 642, 186 7.00	4.00	1 1						4. 00
0.00 0.0000 LANDRY & LINEN SERVICE	5.00	00500 ADMINISTRATIVE & GENERAL	2, 524, 708					5. 00
9.00 0.0900 IOUSEKEEPING	7.00	00700 OPERATION OF PLANT	127, 554	642, 186				7. 00
10.00 01000 DETARY 9,781 15,022 0 0 76,359 10.00 11.00 1								•
11.00 0100 (CAFETERIA 44, 824 18, 211 0 0 0 11.00 15		l l						•
13.00 01300 MURSINK ADMINISTRATION 64, 209 15, 761 0 61 0 13.00 15.00 15.00 16.00 01600 MEDICAR, RECORDS & LIBRARY 801 7, 062 0 20 0 15.00 16.00 0.		l l	1		1	-		1
15.00 01500 PIARBINGY 68, 164 9, 233 0 0 0 15, 00 23 0 23 0 0 0 0 15, 00 23 0 23 0 0 0 0 0 23 0 0 0 0 0 23 0 0 0 0 0 23 0 0 0 0 0 0 0 23 0 0 0 0 0 0 0 0 0 0						-		•
16.00 01-000 MEDICAL RECORDS & LIBRARY 801 7.0c2 0 20 0 23 00		1	1			1		•
23.0 0 03000 ALLIED HALTHI-RAD TECH PROGRAM 11, 037 2, 586 0 0 0 0 23.00					1		-	•
INPATI ENT ROUTINE SERVICE COST CENTERS 222, 628			1		1			1
0.000 0.00000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.00000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.00000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.00000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.00000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.00000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.00000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.00000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.00000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.00000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.00000 0.0000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000000	20.00		11,007	2,000		<u> </u>		20.00
11.00 04100 SUBPROVI DER - 1 RF 141, 134 39, 159 619 6, 140 12, 162 141, 00 A300 A300 MIRSERY 18, 168 4, 644 260 3, 378 7, 413 43, 00 A300 MIRSERY 18, 168 4, 644 260 3, 378 7, 413 43, 00 A300 MIRSERY 18, 168 4, 644 12, 280 0 50, 00	30. 00		222, 628	84, 979	6, 362	25, 111	50, 571	30. 00
A3 OD A30ON NURSERY A1 OD A3 O	31.00	03100 INTENSIVE CARE UNIT	50, 670	16, 266	1, 554	6, 140	6, 213	31. 00
ANCILLARY SERVICE COST CENTERS	41.00	04100 SUBPROVI DER - I RF	41, 134	39, 159	619	6, 140	12, 162	41.00
50, 00	43.00		18, 168	4, 644	260	3, 378	7, 413	43. 00
52.00			T		T			
54.00 05400 RADIOLOGY-DIAGNOSTIC 90,464 68,750 440 1,248 0 54,00 56.00 05600 RADIOLOGY-DIAGNOSTIC 33,5875 5,772 0 921 0 56.00 057.00 05700 07500 0		1	1		1			
54.01 03630 ULTRA SOUND					1			
56. 00 05600 RADIO I SOTOPE 35, 875 5, 772 0 921 0 56. 00 57. 00 0570 0 57. 00 0570 0 57. 00 0570 0 57. 00 0570 0 57. 00 0570 0 58. 00 05800 MAGNETI C RESONANCE I MAGI NG (MRI) 11,074 0 38 0 0 58. 00 05900 0			1		1			1
14, 747 0 159 0 0 57.00 0 57.00 0 57.00 58.00 0 59.00 0 0 59.00 0 0 0 59.00 0 0 0 0 0 0 0 0 0		1						•
58 00 05800 MAGMETI C RESONANCE I IMGI NG (MRI)			1	•		•		•
59.00 05900 CARDIAC CATHETERI ZATION 5,145 1,154 0 409 0 59.00					1			•
65.00 06500 RESPI RATORY THERAPY 48, 308 3, 570 13 123 0 65.00		1 1						ł
66.00 06600 Decomposition 1.00 06700	60.00		156, 678			2, 538	0	60.00
67:00 06700 06700 06700 06700 06700 06700 06800	65.00	06500 RESPI RATORY THERAPY	48, 308	3, 570	13	123	0	65. 00
68.00		1						•
69.00					1			1
70. 00 07000 Color Col						1		•
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 47, 171 12, 436 444 2, 292 0 71. 00 72. 00 72. 00 72. 00 73. 00 73. 00 73. 00 73. 00 73. 00 73. 00 73. 00 73. 00 74. 00								•
72. 00 07200 IMPL DEV. CHARGED TO PATIENTS 80,273 0 1 0 0 72. 00 73. 00 07300 DRUGS CHARGED TO PATIENTS 435,809 0 2 921 0 73. 00 74. 00 07400 RENAL DIALYSIS 7,573 0 0 409 0 74. 00 76. 00 03550 PSYCHIATRI C/PSYCHOLOGI CAL SERVI CES 43,625 13,250 0 8119 0 76. 00 76. 01 03190 CHEMOTHERAPY 139,337 0 0 0 0 0 0 76. 00 76. 02 03330 ENDOSCOPY 8,597 0 0 0 0 0 0 76. 01 76. 02 03330 ENDOSCOPY 8,597 0 0 0 0 0 0 76. 02 76. 03 03950 MOUND CARE CENTER 24,372 8,658 0 1,310 0 76. 03 001PATIENT SERVI CE COST CENTERS 91. 00 09100 BERGENCY 78,825 55,817 2,394 7,368 0 91. 00 92. 00 09200 DISSERVATI ON BEDS (NON-DISTINCT PART) 92. 00 09500 AMBULANCE SERVI CES 35,191 11,452 260 0 0 95. 00 09500 AMBULANCE SERVI CES 35,191 11,452 260 0 0 95. 00 09500 AMBULANCE SERVI CES 35,191 11,452 260 0 0 95. 00 09500 SUBTOTALS (SUM OF LINES 1 through 117) 2,435,454 579,730 19,673 80,189 76,359 118. 00 118. 00 SUBTOTALS (SUM OF LINES 1 through 117) 2,435,454 579,730 19,673 80,189 76,359 118. 00 191. 00 19200 GIFT, FLOWER, COFFEE SHOP & CANTEEN 223 2,970 0 0 0 0 0 192. 00 192. 00 19200 PHYSI CI ANS' PRI VATE OFFI CES 59,465 58,966 0 0 0 0 0 192. 00 192. 01 19201 MARKETI NG 16,430 0 0 0 0 0 192. 01 192. 01 19202 EDUCATION CENTER 568 0 0 0 0 0 192. 01 193. 00 19300 NONPAI D WORKERS 0 0 0 0 0 194. 01 194. 00 07950 CUINIT ON CENTER 568 0 0 0 0 0 194. 01 194. 00 07950 CONSTON THER 500 0 0 0 0 194. 01 194. 00 07950 CONSTON THER 500 0 0 0 0 0 0 0 0					1			•
73. 00 07300 DRUGS CHARGED TO PATIENTS			1					1
74. 00 07400 RENAL DI ALYSIS 7, 573 0 0 409 0 74. 00 76. 00 3550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES 43, 625 13, 250 0 819 0 76. 00 76. 00 76. 01 03190 CHEMOTHERAPY 139, 337 0 0 0 0 0 0 76. 01 76. 02 03330 ENDOSCOPY 8, 597 0 0 0 0 0 76. 02 76. 03 03950 WOUND CARE CENTER 24, 372 8, 658 0 1, 310 0 76. 03 000								•
76. 00 03550 PSYCHIATRI C/PSYCHOLOGI CAL SERVI CES						•		•
76. 02 03330 ENDOSCOPY	76.00	03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES		13, 250	О	819	0	76. 00
76. 03 03950 WOUND CARE CENTER 24, 372 8, 658 0 1, 310 0 76. 03 0UTPATI ENT SERVI CE COST CENTERS 91. 00 09100 [MERGENCY 7, 368 0 91. 00 92. 00 09200] OBSERVATI ON BEDS (NON-DISTINCT PART) 92. 00 09200 [OBSERVATI ON BEDS (NON-DISTINCT PART)] 95. 00 09500 [AMBULANCE SERVI CES	76. 01	03190 CHEMOTHERAPY	139, 337	0	0	0	0	76. 01
91. 00 09100 EMERGENCY 78, 825 55, 817 2, 394 7, 368 0 91. 00 92. 00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART) 92. 00 07 07 07 07 07 07 07	76. 02			0	_	0		76. 02
91. 00	76. 03		24, 372	8, 658	0	1, 310	0	76. 03
92. 00	01 00		70.005	FF 017	2 204	7 2/0	0	01 00
95. 00 OFFICE RELIMBURSABLE COST CENTERS OFFICE S SPECIAL PURPOSE COST CENTERS SPECIAL PURPOSE COST CENTERS SPECIAL PURPOSE COST CENTERS SUBTOTALS (SUM OF LINES 1 through 117) 2, 435, 454 579, 730 19, 673 80, 189 76, 359 118. 00 NONREI MBURSABLE COST CENTERS SUBTOTALS (SUM OF LINES 1 through 117) 2, 435, 454 579, 730 19, 673 80, 189 76, 359 118. 00 NONREI MBURSABLE COST CENTERS SUBTOTALS (SUM OF LINES 1 through 117) 2, 435, 454 579, 730 19, 673 80, 189 76, 359 118. 00 NONREI MBURSABLE COST CENTERS SUBTOTALS (SUM OF LINES 1 through 117) 2, 435, 454 579, 730 19, 673 80, 189 76, 359 118. 00 NONPEI MBURSABLE COST CENTERS SUBTOTALS (SUM OF LINES 1 through 117) 2, 435, 454 579, 730 19, 673 80, 189 76, 359 118. 00 NONPEI MBURSABLE COST CENTERS SUBTOTALS (SUM OF LINES 1 through 117) 2, 435, 454 579, 730 19, 673 80, 189 76, 359 118. 00 SUBTOTALS (SUM OF LINES 1 through 117) 2, 435, 454 579, 730 19, 673 80, 189 76, 359 118. 00 SUBTOTALS (SUM OF LINES 1 through 117) 2, 435, 454 579, 730 19, 673 80, 189 76, 359 118. 00 SUBTOTALS (SUM OF LINES 1 through 117) 2, 435, 454 579, 730 19, 673 80, 189 76, 359 118. 00 SUBTOTALS (SUM OF LINES 1 through 117) 2, 435, 454 579, 730 19, 673 80, 189 76, 359 118. 00 SUBTOTALS (SUM OF LINES 1 through 117) 2, 435, 454 579, 730 19, 673 80, 189 76, 359 118. 00 SUBTOTALS (SUM OF LINES 1 through 117) 2, 435, 454 579, 730 19, 673 80, 189 76, 359 118. 00 SUBTOTALS (SUM OF LINES 1 through 117) 2, 435, 454 579, 730 19, 673 80, 189 76, 359 118. 00 SUBTOTALS (SUM OF LINES 1 through 117) 2, 435, 454 579, 730 19, 673 80, 189 76, 359 118. 00 SUBTOTALS (SUM OF LINES 1 through 117) 2, 435, 454 579, 730 19, 673 80, 189 76, 359 118. 00 SUBTOTALS (SUM OF LINES 1 through 117) 2, 435, 454 579, 730 19, 673 80, 189 76, 359 118. 00 SUBTOTALS (SUM OF LINES 1 through 117) 2, 435, 454 579, 730 19, 673 80, 189 87, 189 118. 00 SUBTOTALS (SUM OF LINES 1 through 117) 2, 435, 454 579, 730 19, 673 80, 189 87, 189 118. 00 SUBTOTALS (SUM OF LINES 1 through 117) 2, 435, 454 579, 730 19, 673 80, 189 87, 189 80, 189 87, 189 80,			/8, 825	55, 817	2, 394	7, 368	0	
95. 00 09500 AMBULANCE SERVI CES 35, 191 11, 452 260 0 0 95. 00 SPECIAL PURPOSE COST CENTERS 113. 00 11300 INTEREST EXPENSE 113. 00 SUBTOTALS (SUM OF LI NES 1 through 117) 2, 435, 454 579, 730 19, 673 80, 189 76, 359 118. 00 NONREI MBURSABLE COST CENTERS 118. 00 NONREI MBURSABLE COST CENTERS 119. 00 19000 GI FT, FLOWER, COFFEE SHOP & CANTEEN 223 2, 970 0 0 0 0 190. 00 191. 00 192. 00 19200 PHYSI CI ANS' PRI VATE OFFI CES 59, 465 58, 966 0 0 0 0 192. 00 192. 00 192. 01 19201 MARKETI NG 16, 430 0 0 0 0 192. 01 192. 02 19202 EDUCATI ON CENTER 568 0 0 0 0 192. 02 193. 00 19300 NONPAI D WORKERS 0 0 0 0 0 193. 00 194. 01 07951 ASPR BI OTERRORI SM GRANT 232 0 0 0 0 194. 01 194. 02 07952 CLI NI C OF HOPE 12, 294 0 0 0 0 0 194. 02 200. 00 Negati ve Cost Centers 0 0 0 0 0 0 0 201. 00 0 0 0 0 0 0 0 0 0	92.00							92.00
SPECIAL PURPOSE COST CENTERS 113.00 INTEREST EXPENSE SUBTOTALS (SUM OF LINES 1 through 117) 2,435,454 579,730 19,673 80,189 76,359 118.00 NONREI MBURSABLE COST CENTERS	95 00		35 191	11 452	260	0	0	95 00
113.00	70.00		00/1/1	117 102		<u>~_</u>		70.00
NONRET MBURSABLE COST CENTERS 190. 00 19000 GI FT, FLOWER, COFFEE SHOP & CANTEEN 223 2,970 0 0 0 0 190. 00 191. 00 19100 RESEARCH 0 0 0 0 0 191. 00 192. 00 19200 PHYSI CI ANS' PRI VATE OFFI CES 59, 465 58, 966 0 0 0 192. 00 192. 01 19201 MARKETI NG 16, 430 0 0 0 0 192. 01 192. 02 19202 EDUCATI ON CENTER 568 0 0 0 0 192. 02 193. 00 19300 NONPAI D WORKERS 0 0 0 0 0 193. 00 194. 00 07950 FOUNDATI ON 42 520 0 0 0 194. 00 194. 01 07951 ASPR BI OTERRORI SM GRANT 232 0 0 0 0 194. 01 194. 02 07952 CLI NI C OF HOPE 12, 294 0 0 0 0 194. 01 200. 00 Negati ve Cost Centers 0 0 0 0 0 201. 00 190. 00 190. 00 0 0 0 0 0 190. 00 0 0 0 0 0 190. 00 0 0 0 0 190. 00 0 0 0 0 190. 00 0 0 0 0 190. 00 0 0 0 0 190. 00 0 0 0 0 190. 00 0 0 0 0 190. 00 0 0 0 0 190. 00 0 0 190. 00 0 0 190. 00 0 0 0 190. 00 0 0 190. 00 0 0 190. 00 0 0 190. 00 0 0 190. 00 0 0 190. 00 0 0 190. 00 0 0 190. 00 0 0 190. 00 0 0 190. 00 0 0 190. 00 0 0 190. 00 0 0 190. 00 0 0 190. 00 0 0 190. 00 0 0 190. 00 0 0 190. 00 0 190. 00 0 0 190. 00 0 0 190. 00 0 190. 00 0 0	113.00							113. 00
190. 00			2, 435, 454	579, 730	19, 673	80, 189	76, 359	118. 00
191. 00		NONREI MBURSABLE COST CENTERS						
192. 00 19200 PHYSI CI ANS' PRI VATE OFFI CES 59, 465 58, 966 0 0 0 192. 00 192. 00 192. 01 19201 MARKETI NG 16, 430 0 0 0 0 192. 01 192. 02 19202 EDUCATI ON CENTER 568 0 0 0 0 0 192. 02 193. 00 19300 NONPAI D WORKERS 0 0 0 0 0 0 193. 00 194. 00 07950 FOUNDATI ON 42 520 0 0 0 194. 00 194. 00 194. 01 07951 ASPR BI OTERRORI SM GRANT 232 0 0 0 0 194. 00 194. 02 07952 CLI NI C OF HOPE 12, 294 0 0 0 0 194. 02 200. 00 Negati ve Cost Centers 0 0 0 0 0 0 0 0 100. 00 0 0 0 0 100. 00			1					
192. 01 19201 MARKETING 16, 430 0 0 0 0 192. 01 192. 01 192. 02 19202 EDUCATION CENTER 568 0 0 0 0 0 192. 02 193. 00 19300 NONPAID WORKERS 0 0 0 0 0 0 193. 00 194. 00 07950 FOUNDATION 42 520 0 0 0 194. 00 194. 01 07951 ASPR BIOTERRORISM GRANT 232 0 0 0 0 194. 01 194. 02 07952 CLINIC OF HOPE 12, 294 0 0 0 0 194. 02 200. 00 Negative Cost Centers 0 0 0 0 0 0 0 0 201. 00			1 -1					
192. 02 19202 EDUCATION CENTER 568 0 0 0 0 192. 02 193. 00 19300 NONPAID WORKERS 0 0 0 0 0 193. 00 194. 00 07950 FOUNDATION 42 520 0 0 0 194. 00 194. 00 194. 01 07951 ASPR BIOTERRORISM GRANT 232 0 0 0 0 194. 01 194. 01 194. 02 07952 CLINIC OF HOPE 12, 294 0 0 0 0 194. 01 194. 0						0		1
193. 00					_	0		
194. 00 07950 FOUNDATION 42 520 0 0 0 194. 00 194. 01 07951 ASPR BIOTERRORISM GRANT 232 0 0 0 0 194. 01 194. 02 07952 CLINIC OF HOPE 12, 294 0 0 0 0 194. 02 200. 00 Cross Foot Adjustments 0 0 0 0 0 0 201. 00			1			0		
194. 01 07951 ASPR BIOTERRORISM GRANT 232 0 0 0 0 194. 01 194. 02 194. 02 07952 CLINIC OF HOPE 12, 294 0 0 0 0 194. 02 200. 00 0 0 0 0 0 0 0 0 0 0 0 0 0 0			-1		1	0		
194. 02 07952 CLINIC OF HOPE 12, 294 0 0 0 0 194. 02 200. 00 Cross Foot Adjustments 200. 00 201. 00 Negative Cost Centers 0 0 0 0 0 0		l l		0	0	ol		1
200.00 Cross Foot Adjustments 200.00 201.00 Negative Cost Centers 0 0 0 0 0 0 0 201.00				0	ol ol	ol		1
201.00 Negative Cost Centers 0 0 0 0 201.00			'					
202.00 TOTAL (sum lines 118 through 201) 2,524,708 642,186 19,673 80,189 76,359 202.00	201.00	Negative Cost Centers	0	0	0	o		
	202.00	TOTAL (sum lines 118 through 201)	2, 524, 708	642, 186	19, 673	80, 189	76, 359	202. 00

Heal th Financial Systems

ST. JOSEPH HOSPITAL & HEALTH CENTER

In Lieu of Form CMS-2552-10

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 15-0010
From 07/01/2017
To 06/30/2018

Date/Time Prepared:

					o 06/30/2018		pared:
	Cost Center Description	CAFETERI A	NURSI NG ADMI NI STRATI ON	PHARMACY	MEDI CAL RECORDS & LI BRARY	ALLIED HEALTH-RAD TECH PROGRAM	: U3 piii
		11. 00	13. 00	15. 00	16.00	23. 00	
	GENERAL SERVICE COST CENTERS						
1. 00 2. 00 4. 00 5. 00	00100 CAP REL COSTS-BLDG & FIXT 00200 CAP REL COSTS-MVBLE EQUIP 00400 EMPLOYEE BENEFITS DEPARTMENT 00500 ADMINISTRATIVE & GENERAL						1. 00 2. 00 4. 00 5. 00
7. 00 8. 00 9. 00	00700 OPERATION OF PLANT 00800 LAUNDRY & LINEN SERVICE 00900 HOUSEKEEPING						7. 00 8. 00 9. 00
10. 00 11. 00	01000 DI ETARY 01100 CAFETERI A	132, 961	202 442				10.00
13. 00 15. 00 16. 00	01300 NURSI NG ADMI NI STRATI ON 01500 PHARMACY 01600 MEDI CAL RECORDS & LI BRARY	5, 593 5, 468	303, 442 0 0	113, 050	1		13. 00 15. 00 16. 00
23. 00	02300 ALLIED HEALTH-RAD TECH PROGRAM INPATIENT ROUTINE SERVICE COST CENTERS	1, 280	0	C	1	22, 848	23. 00
30. 00	03000 ADULTS & PEDIATRICS	25, 758	109, 323	C	1, 998		30.00
31. 00	03100 INTENSIVE CARE UNIT	5, 039	21, 385	C	487		31. 00
41. 00	04100 SUBPROVI DER - I RF	4, 667	19, 808	C			41. 00
43. 00	04300 NURSERY ANCI LLARY SERVI CE COST CENTERS	1, 848	7, 845	C	273		43. 00
50. 00	05000 OPERATING ROOM	16, 345	69, 369	C	5, 731		50.00
52. 00	05200 DELIVERY ROOM & LABOR ROOM	5, 601	23, 769	C			52.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	6, 354	o	C	1, 665		54.00
54. 01	03630 ULTRA SOUND	1, 060	0	C			54. 01
56.00	05600 RADI OI SOTOPE 05700 CT SCAN	2, 510	0	C	.,		56.00
57. 00 58. 00	05800 MAGNETIC RESONANCE IMAGING (MRI)	1, 394 1, 222	0	C			57. 00 58. 00
59. 00	05900 CARDI AC CATHETERI ZATI ON	260	1, 102	C	1		59.00
60.00	06000 LABORATORY	0	0	C	4, 657		60. 00
65. 00	06500 RESPI RATORY THERAPY	4, 833	0	C	1 020		65. 00
66.00	06600 PHYSI CAL THERAPY	8, 786	0	C	1		66.00
67. 00 68. 00	06700 OCCUPATI ONAL THERAPY 06800 SPEECH PATHOLOGY	3, 141 783	0	C	1 0.2		67. 00 68. 00
69. 00	06900 ELECTROCARDI OLOGY	2, 772	0	(994		69.00
70. 00	07000 ELECTROENCEPHALOGRAPHY	1, 897	o	C	1		70.00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	1, 907	О	C	1, 009		71. 00
72. 00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	C	-		72. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0	112, 948			73.00
74. 00 76. 00	07400 RENAL DI ALYSI S 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	0 5, 970	0	C	1		74. 00 76. 00
76. 00	03190 CHEMOTHERAPY	2, 396	10, 170	(1		76. 00
76. 02	03330 ENDOSCOPY	306	1, 297	Č	1		76. 02
76. 03	03950 WOUND CARE CENTER	1, 208	5, 127	C	971		76. 03
04.00	OUTPATIENT SERVICE COST CENTERS	0.040	04.047		1 075		04 00
91. 00 92. 00	09100 EMERGENCY 09200 OBSERVATION BEDS (NON-DISTINCT PART)	8, 069	34, 247	C	4, 275		91. 00 92. 00
05 00	OTHER REIMBURSABLE COST CENTERS	5, 078	ما				05.00
95.00	09500 AMBULANCE SERVICES SPECIAL PURPOSE COST CENTERS	5,078	0	C	574		95. 00
113. 00	11300 I NTEREST EXPENSE						113. 00
118.00		131, 545	303, 442	112, 948	35, 197	0	118. 00
	NONREI MBURSABLE COST CENTERS						
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	C			190. 00
	19100 RESEARCH 19200 PHYSICIANS' PRIVATE OFFICES	0 210	0	C			191. 00 192. 00
	19201 MARKETING	0	0	(1		192. 00
	19202 EDUCATION CENTER	o	o	Č	o o		192. 02
193.00	19300 NONPALD WORKERS	0	0	C	o		193. 00
	07950 FOUNDATION	0	0	C	0		194. 00
	07951 ASPR BIOTERRORISM GRANT	0	0	100	1		194. 01
194. 02 200. 00	207952 CLINIC OF HOPE Cross Foot Adjustments	1, 206	O	102		22, 848	194. 02
200.00		o	0	C	ol		201. 00
202.00		132, 961	303, 442	113, 050	35, 197	22, 848	

Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS

| In Lieu of Form CMS-2552-10 | Period: | Worksheet B | From 07/01/2017 | Part II | To 06/30/2018 | Date/Time Prepared:

			To		
Cost Center Description	Subtotal	Intern &	Total	11/26/2018	12: U3 pili
'		Residents Cost			
		& Post Stepdown			
		Adjustments			
	24. 00	25. 00	26. 00		
GENERAL SERVICE COST CENTERS 1.00 OO100 CAP REL COSTS-BLDG & FLXT					1.00
2.00 O0200 CAP REL COSTS-MVBLE EQUIP					2.00
4.00 00400 EMPLOYEE BENEFITS DEPARTMENT					4. 00
5.00 00500 ADMINISTRATIVE & GENERAL					5. 00
7.00 00700 OPERATION OF PLANT 8.00 00800 LAUNDRY & LINEN SERVICE					7. 00 8. 00
9. 00 00900 HOUSEKEEPI NG					9. 00
10. 00 01000 DI ETARY					10. 00
11. 00 01100 CAFETERI A					11.00
13. 00 01300 NURSI NG ADMI NI STRATI ON 15. 00 01500 PHARMACY					13. 00 15. 00
16. 00 01600 MEDI CAL RECORDS & LI BRARY					16. 00
23.00 02300 ALLIED HEALTH-RAD TECH PROGRAM					23. 00
I NPATI ENT ROUTI NE SERVI CE COST CENTERS	017 540	ما	017 540		20.00
30. 00 03000 ADULTS & PEDIATRICS 31. 00 03100 INTENSIVE CARE UNIT	917, 542 173, 698	0	917, 542 173, 698		30. 00 31. 00
41. 00 04100 SUBPROVI DER - RF	234, 554	Ö	234, 554		41. 00
43. 00 04300 NURSERY	75, 190	0	75, 190		43. 00
ANCILLARY SERVICE COST CENTERS 50. 00 OFERATING ROOM	1, 012, 550	o	1, 012, 550		50.00
52.00 05200 DELI VERY ROOM & LABOR ROOM	183, 937	0	183, 937		52.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	752, 659	O	752, 659		54. 00
54. 01 03630 ULTRA SOUND	23, 909	0	23, 909		54. 01
56. 00 05600 RADI 0I SOTOPE 57. 00 05700 CT SCAN	90, 278 20, 039	0	90, 278 20, 039		56. 00 57. 00
58.00 05800 MAGNETIC RESONANCE I MAGING (MRI)	13, 383	0	13, 383		58.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	27, 768	0	27, 768		59. 00
60. 00 06000 LABORATORY	252, 098	0	252, 098		60.00
65. 00 06500 RESPI RATORY THERAPY 66. 00 06600 PHYSI CAL THERAPY	124, 768 219, 795	0	124, 768 219, 795		65. 00 66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	84, 900	0	84, 900		67. 00
68.00 06800 SPEECH PATHOLOGY	24, 370	0	24, 370		68. 00
69. 00 06900 ELECTROCARDI OLOGY	229, 018	0	229, 018		69. 00
70. 00 07000 ELECTROENCEPHALOGRAPHY 71. 00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS	79, 285 180, 118	0	79, 285 180, 118		70. 00 71. 00
72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS	81, 156	Ö	81, 156		72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	553, 577	0	553, 577		73. 00
74. 00 07400 RENAL DI ALYSI S 76. 00 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	7, 999 104, 020	0	7, 999 104, 020		74. 00 76. 00
76. 00 03330 PSTCHIATRIC/PSTCHOLOGICAL SERVICES 76. 01 03190 CHEMOTHERAPY	153, 606	0	153, 606		76. 00
76. 02 03330 ENDOSCOPY	89, 829	0	89, 829		76. 02
76. 03 03950 WOUND CARE CENTER	73, 599	0	73, 599		76. 03
91.00 OUTPATIENT SERVICE COST CENTERS 91.00 O9100 EMERGENCY	421, 178	0	421, 178		91. 00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)		Ö	121, 170		92. 00
OTHER REIMBURSABLE COST CENTERS		-1			
95. 00 09500 AMBULANCE SERVICES SPECIAL PURPOSE COST CENTERS	225, 737	0	225, 737		95. 00
113. 00 11300 I NTEREST EXPENSE					113. 00
118.00 SUBTOTALS (SUM OF LINES 1 through 11	17) 6, 430, 560	0	6, 430, 560		118. 00
NONREI MBURSABLE COST CENTERS 190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	11, 309	ol	11 200		190. 00
191. 00 19100 RESEARCH	11, 309	0	11, 309 0		190.00
192.00 19200 PHYSI CLANS' PRI VATE OFFI CES	292, 498	0	292, 498		192. 00
192. 01 19201 MARKETI NG	16, 430	0	16, 430		192. 01
192. 02 19202 EDUCATION CENTER 193. 00 19300 NONPALD WORKERS	568 0	0	568 0		192. 02 193. 00
194. 00 07950 FOUNDATION	2, 079	ol	2, 079		194. 00
194.01 07951 ASPR BIOTERRORISM GRANT	232	0	232		194. 01
194. 02 07952 CLINIC OF HOPE	15, 092	0	15, 092		194. 02
200.00 Cross Foot Adjustments 201.00 Negative Cost Centers	22, 848	0	22, 848 0		200. 00 201. 00
202.00 TOTAL (sum lines 118 through 201)	6, 791, 616		6, 791, 616		202. 00
	'	'	'		•

In Lieu of Form CMS-2552-10 Health Financial Systems ST. JOSEPH HOSPITAL & HEALTH CENTER COST ALLOCATION - STATISTICAL BASIS Provider CCN: 15-0010 Peri od: Worksheet B-1 From 07/01/2017 06/30/2018 Date/Time Prepared: 11/26/2018 12:03 pm CAPITAL RELATED COSTS Cost Center Description BLDG & FIXT MVBLE EQUIP **EMPLOYEE** Reconciliation ADMINISTRATIVE (SQUARE FEET) (DOLLAR VALUE) BENEFITS & GENERAL (ACCUM. COST) DEPARTMENT (GROSS SALARI ES) 1.00 2.00 5A 5. 00 GENERAL SERVICE COST CENTERS 1 00 00100 CAP REL COSTS-BLDG & FLXT 331, 432 1 00 2.00 00200 CAP REL COSTS-MVBLE EQUIP 1, 689, 841 2 00 4.00 00400 EMPLOYEE BENEFITS DEPARTMENT 12,820 200 35, 656, 036 4.00 00500 ADMINISTRATIVE & GENERAL 4, 519, 849 5 00 -30, 927, 460 92 040 851 5 00 50 113 6, 693 7.00 00700 OPERATION OF PLANT 45, 990 123, 380 292, 632 4, 650, 169 7.00 8.00 00800 LAUNDRY & LINEN SERVICE 518 513, 764 8.00 00900 HOUSEKEEPI NG 2,015 4, 768 0 1, 696, 259 9.00 9.00 0 01000 DI ETARY 10.00 5.205 0 356, 568 10 00 8, 578 11.00 01100 CAFETERI A 6, 310 16, 463 n 1, 634, 110 11.00 01300 NURSING ADMINISTRATION 1, 550, 060 0 2, 340, 827 13.00 5, 461 139, 111 13.00 0 01500 PHARMACY 15.00 3.199 1, 742, 622 2, 485, 033 15.00 01600 MEDICAL RECORDS & LIBRARY 16.00 2.447 6, 546 29, 195 16.00 23.00 02300 ALLIED HEALTH-RAD TECH PROGRAM 896 308, 745 402, 356 23.00 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 29, 444 116, 660 5, 539, 913 0 8, 116, 224 30.00 31.00 03100 INTENSIVE CARE UNIT 5.636 14, 627 1, 260, 101 0 1,847,265 31 00 41.00 04100 SUBPROVI DER - I RF 13, 568 1, 012, 706 0 1, 499, 590 41.00 462 43.00 04300 NURSERY 1,609 14, 237 435, 596 662, 327 43.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 32, 649 277, 606 3, 714, 760 7, 524, 818 50 00 05200 DELIVERY ROOM & LABOR ROOM 3, 264 1, 319, 833 0 1, 994, 100 52.00 43, 138 52.00 54.00 05400 RADI OLOGY-DI AGNOSTI C 320, 192 1, 334, 292 0 3, 298, 013 23.821 54.00 54.01 03630 ULTRA SOUND 6, 507 322, 778 476, 054 54.01 56.00 05600 RADI OI SOTOPE 2,000 21, 262 730, 929 1, 307, 888 56.00 05700 CT SCAN 390, 264 57.00 1, 553 0 0 0 0 0 0 537, 614 57.00 58.00 05800 MAGNETIC RESONANCE I MAGING (MRI) 0 298, 992 403, 727 58.00 05900 CARDIAC CATHETERIZATION 59.00 400 13, 248 70, 165 187, 565 59 00 06000 LABORATORY 7,900 2, 534 5, 711, 907 60.00 60.00 65.00 06500 RESPIRATORY THERAPY 1, 237 44, 109 1, 171, 050 1, 761, 149 65.00 2, 160, 584 06600 PHYSI CAL THERAPY 7, 215 3, 204, 555 66,00 31.040 66,00 06700 OCCUPATI ONAL THERAPY 67.00 3,096 11, 097 772, 449 1, 172, 742 67.00 06800 SPEECH PATHOLOGY 192, 549 294, 446 68.00 1,040 2, 766 0 0 0 0 0 0 0 68.00 06900 ELECTROCARDI OLOGY 4,003 122, 395 658, 428 1, 101, 713 69.00 69.00 07000 ELECTROENCEPHALOGRAPHY 2, 728 20, 482 402, 697 70.00 739, 020 70.00 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 4, 309 65, 396 280, 388 1, 719, 670 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 2, 926, 467 72.00 15, 887, 111 07300 DRUGS CHARGED TO PATIENTS 73 00 0 Ω 0 73 00 07400 RENAL DIALYSIS 74.00 Ω C Ω 276, 082 74.00 76.00 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES 4, 591 0 1, 330, 419 1, 590, 407 76.00 03190 CHEMOTHERAPY 0 76. 01 479, 139 5, 079, 725 76.01 03330 ENDOSCOPY 0 76 02 64, 649 91 919 313, 402 76 02 76.03 03950 WOUND CARE CENTER 3,000 6, 249 225, 151 888, 503 76.03 OUTPATIENT SERVICE COST CENTERS 91.00 09100 EMERGENCY 19.340 59, 027 1, 888, 701 2, 873, 682 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 92.00 92.00 OTHER REIMBURSABLE COST CENTERS 09500 AMBULANCE SERVICES 95.00 3, 968 114, 071 776, 126 0 1, 282, 948 95.00 SPECIAL PURPOSE COST CENTERS 113.00 11300 INTEREST EXPENSE 113.00 118.00 SUBTOTALS (SUM OF LINES 1 through 117) 309, 792 1, 679, 046 35, 273, 837 -30, 927, 460 88, 786, 995 118. 00 NONREI MBURSABLE COST CENTERS 190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 8, 116 190. 00 1.029 0 191. 00 19100 RESEARCH 0 0 0 191.00 192.00 19200 PHYSICIANS' PRIVATE OFFICES 10, 217 0 2, 167, 869 192. 00 20.431 72, 966 0 192. 01 19201 MARKETI NG 598, 981 192. 01 C 192. 02 19202 EDUCATION CENTER 20, 716 192. 02 0 0 Ω 193. 00 19300 NONPALD WORKERS 0 C 0 0 193.00 194. 00 07950 FOUNDATI ON 180 79 0 1, 517 194. 00 194. 01 07951 ASPR BI OTERRORI SM GRANT 8, 460 194. 01 0 0 0 309, 233 194. 02 07952 CLINIC OF HOPE 0 499 448, 197 194. 02 200.00 Cross Foot Adjustments 200.00 201.00 Negative Cost Centers 201.00 202.00 Cost to be allocated (per Wkst. B, 2, 614, 003 2,069,190 8, 742, 383 30, 927, 460 202. 00 Part I) 203.00 Unit cost multiplier (Wkst. B, Part I) 7.886996 1. 224488 0.245187 0. 336019 203. 00

101, 356

2, 524, 708 204. 00

Part II)

Cost to be allocated (per Wkst. B,

Heal th Finar	ncial Systems ST.	JOSEPH HOSPITA	L & HEALTH CENT	ER	In Lieu of Form CMS-2552-10			
COST ALLOCATION - STATISTICAL BASIS			Provi der CO		Period: From 07/01/2017	Worksheet B-1		
					To 06/30/2018	Date/Time Pre 11/26/2018 12		
		CAPITAL REI	LATED COSTS					
	Cost Center Description	BLDG & FLXT (SQUARE FEET)	MVBLE EQUIP (DOLLAR VALUE)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)		
		1. 00	2. 00	4. 00	5A	5. 00		
205. 00	Unit cost multiplier (Wkst. B, Part			0. 00284	3	0. 027430	205. 00	
206. 00	NAHE adjustment amount to be allocated (per Wkst. B-2)						206. 00	
207. 00	NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207. 00	

		JOSEPH HOSPITA				u of Form CMS-	
COST A	ILLOCATION - STATISTICAL BASIS		Provi der CC	F	eriod: from 07/01/2017 fo 06/30/2018		pared:
	Cost Center Description	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LI NEN SERVI CE (POUNDS OF LAUNDRY)	HOUSEKEEPING (HOURS OF SERVICE)	DIETARY (TOTAL PATIENT DAYS)	11/26/2018 12 CAFETERI A (MANHOURS)	2. 03 piii
		7. 00	8. 00	9. 00	10.00	11. 00	
	GENERAL SERVI CE COST CENTERS						
1. 00 2. 00 4. 00 5. 00 7. 00 8. 00 9. 00	00100 CAP REL COSTS-BLDG & FIXT 00200 CAP REL COSTS-MVBLE EQUIP 00400 EMPLOYEE BENEFITS DEPARTMENT 00500 ADMINISTRATIVE & GENERAL 00700 OPERATION OF PLANT 00800 LAUNDRY & LINEN SERVICE 00900 HOUSEKEEPING	222, 509 518 2, 015	497, 077 154, 502	195, 900	1		1. 00 2. 00 4. 00 5. 00 7. 00 8. 00 9. 00
10. 00 11. 00	01000 DI ETARY 01100 CAFETERI A	5, 205 6, 310	I .		, , ,	1, 013, 033	10.00
13.00	01300 NURSI NG ADMI NI STRATI ON	5, 461	l e	150		42, 611	1
15.00	01500 PHARMACY	3, 199	0	C	o	41, 664	15.00
16. 00	01600 MEDI CAL RECORDS & LI BRARY	2, 447	l e			0 754	
23. 00	02300 ALLIED HEALTH-RAD TECH PROGRAM INPATIENT ROUTINE SERVICE COST CENTERS	896	0	C	0	9, 754	23. 0
30.00	03000 ADULTS & PEDI ATRI CS	29, 444	160, 694	61, 341	14, 748	196, 260	30.00
31. 00	03100 NTENSI VE CARE UNI T	5, 636			· · · · · · · · · · · · · · · · · · ·	38, 390	1
41. 00 43. 00	04100 SUBPROVI DER - RF 04300 NURSERY	13, 568 1, 609				35, 559 14, 083	
43.00	ANCI LLARY SERVI CE COST CENTERS	1,007	0,372	0, 232	2, 102	14, 003	45.00
50.00	05000 OPERATING ROOM	32, 649				124, 532	
52. 00	05200 DELIVERY ROOM & LABOR ROOM	3, 264				42, 671	1
54. 00 54. 01	05400 RADI OLOGY-DI AGNOSTI C 03630 ULTRA SOUND	23, 821				48, 410 8, 073	
56.00	05600 RADI OI SOTOPE	2,000		2, 250		19, 125	
57. 00	05700 CT SCAN	0			-	10, 618	
58. 00 59. 00	05800 MAGNETIC RESONANCE I MAGING (MRI) 05900 CARDIAC CATHETERIZATION	400	1	1 000		9, 312 1, 979	
60.00	06000 LABORATORY	7, 900		1, 000 6, 200		1, 9/9	1
65. 00	06500 RESPIRATORY THERAPY	1, 237	I .	300		36, 822	1
66. 00	06600 PHYSI CAL THERAPY	7, 215		691		66, 938	
67. 00 68. 00	O6700 OCCUPATI ONAL THERAPY O6800 SPEECH PATHOLOGY	3, 096 1, 040	l l	347 712	1	23, 931 5, 965	
69. 00	06900 ELECTROCARDI OLOGY	4, 003	l l	400	1	21, 118	
70. 00	07000 ELECTROENCEPHALOGRAPHY	2, 728	0	2, 550	o	14, 453	
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	4, 309			l l	14, 533	
72. 00 73. 00	07200 IMPL. DEV. CHARGED TO PATIENTS 07300 DRUGS CHARGED TO PATIENTS	0	1		_	0	1
74. 00	07400 RENAL DIALYSIS	0	0	1, 000		0	1
76. 00	03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	4, 591	0	2, 000		45, 486	
76. 01 76. 02	03190 CHEMOTHERAPY 03330 ENDOSCOPY				-	18, 257 2, 328	76. 0 76. 0
	03950 WOUND CARE CENTER	3,000	o o				76. 0
	OUTPATIENT SERVICE COST CENTERS						
91. 00 92. 00	09100 EMERGENCY 09200 OBSERVATION BEDS (NON-DISTINCT PART)	19, 340	60, 482	18, 000	0	61, 481	91. 0
95 00	OTHER REIMBURSABLE COST CENTERS O9500 AMBULANCE SERVI CES	3, 968	6, 565	С	O	38, 689	95. 0
	SPECIAL PURPOSE COST CENTERS	3, 700	0, 303			30, 007	
113.00	11300 INTEREST EXPENSE SUBTOTALS (SUM OF LINES 1 through 117)	200, 869	497, 077	195, 900	22, 269	1, 002, 246	113. 0 118. 0
	NONREI MBURSABLE COST CENTERS						
	1900 GIFT, FLOWER, COFFEE SHOP & CANTEEN 1910 RESEARCH	1, 029	1	· ·			190. 0 191. 0
	19200 PHYSICIANS' PRIVATE OFFICES	20, 431	Ί		1		192. 0
192.01	19201 MARKETI NG	0	0	C		0	192. 0
	19202 EDUCATION CENTER	0	0	0	0		192. 0
	19300 NONPAID WORKERS 07950 FOUNDATION	180		i d			193. 0 194. 0
	07951 ASPR BIOTERRORISM GRANT	0	Ö	C	o		194. 0
	07952 CLINIC OF HOPE	0	0	C	0	9, 185	194. 0
200.00							200. 0
202. 00		6, 212, 714	700, 861	2, 540, 337	621, 712	2, 359, 385	
203. 00 204. 00	Unit cost multiplier (Wkst. B, Part I)	27. 921181 642, 186	l e			2. 329031 132, 961	
	Part II)	2. 886112		0. 409336		0. 131250	
205.00			i .	1	1		1

Health Financial Systems ST.	JOSEPH HOSPITA	L & HEALTH CENT	TER	In Lie	u of Form CMS-:	2552-10
COST ALLOCATION - STATISTICAL BASIS		Provi der CO		Peri od:	Worksheet B-1	
				From 07/01/2017 To 06/30/2018	Date/Time Pre 11/26/2018 12	
Cost Center Description	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	CAFETERI A	
	PLANT	LINEN SERVICE	(HOURS OF	(TOTAL PATIENT	(MANHOURS)	
	(SQUARE FEET)	(POUNDS OF	SERVI CE)	DAYS)		
		LAUNDRY)				
	7. 00	8. 00	9. 00	10.00	11. 00	
207.00 NAHE unit cost multiplier (Wkst. D,						207. 00
Parts III and IV)						

	nancial Systems ST.	JOSEPH HOSPITAL	& HEALTH CENT	ER	In Lie	u of Form CMS-2552-
COST ALLO	OCATION - STATISTICAL BASIS		Provi der CC	N: 15-0010 P	eriod: rom 07/01/2017	Worksheet B-1
					o 06/30/2018	
	Cost Center Description	NURSI NG	PHARMACY	MEDI CAL	ALLI ED	11/26/2018 12:03 p
		ADMI NI STRATI ON	(COSTED	RECORDS &	HEALTH-RAD	
		(5) 5507 11150	REQUI S.)	LIBRARY	TECH PROGRAM	
		(DI RECT NURS.		(GROSS CHARGES)	(RADI OLOGY	
		HRS.) 13. 00	15. 00	16. 00	CHARGES) 23.00	
GEN	NERAL SERVICE COST CENTERS	10.00	10.00	10.00	20.00	
	100 CAP REL COSTS-BLDG & FIXT					1. (
	200 CAP REL COSTS-MVBLE EQUIP					2.0
	400 EMPLOYEE BENEFITS DEPARTMENT 500 ADMINISTRATIVE & GENERAL					4.0
	700 OPERATION OF PLANT	-				5. (
1	800 LAUNDRY & LINEN SERVICE					8. (
1	900 HOUSEKEEPI NG					9. (
	000 DI ETARY					10. (
	100 CAFETERI A					11. (
	300 NURSI NG ADMI NI STRATI ON	544, 744	4 200 (02			13. (
	500 PHARMACY 600 MEDICAL RECORDS & LIBRARY	0	4, 388, 682 0	518, 872, 850		15. (16. (
	300 ALLIED HEALTH-RAD TECH PROGRAM	o o	o	0 0 0 10 0 10 0		23. (
	PATIENT ROUTINE SERVICE COST CENTERS		-1	-	22/211/211	==-
	000 ADULTS & PEDIATRICS	196, 260	0	29, 386, 057	0	30.
	100 I NTENSI VE CARE UNI T	38, 390	0	7, 168, 994		31. (
	100 SUBPROVI DER - I RF	35, 559	0	6, 022, 023		41. (
	300 NURSERY CILLARY SERVICE COST CENTERS	14, 083	0	4, 012, 318	0	43. (
	OOO OPERATING ROOM	124, 532	O	85, 536, 282	0	50. (
	200 DELIVERY ROOM & LABOR ROOM	42, 671	O	13, 471, 098		52. (
54. 00 054	400 RADI OLOGY-DI AGNOSTI C	0	0	24, 490, 166	24, 490, 167	54. (
1	630 ULTRA SOUND	0	0	8, 204, 204		54. (
	600 RADI OI SOTOPE	0	0	19, 302, 004		56.0
	700 CT SCAN 800 MAGNETIC RESONANCE IMAGING (MRI)	0	0	10, 685, 097 2, 930, 175		57. (58. (
	900 CARDI AC CATHETERI ZATI ON	1, 979	0	1, 787, 397	2, 930, 174	59.0
	000 LABORATORY	0	0	68, 490, 956	O	60.
	500 RESPI RATORY THERAPY	0	0	12, 130, 031	0	65. (
	600 PHYSI CAL THERAPY	0	0	13, 904, 695		66.
	700 OCCUPATI ONAL THERAPY	0	0	4, 589, 508		67. (
	800 SPEECH PATHOLOGY 900 ELECTROCARDIOLOGY	0	O O	1, 014, 272 14, 616, 280	1	68. (
	000 ELECTROEAGH OLOGT		0	6, 744, 909		70.0
	100 MEDICAL SUPPLIES CHARGED TO PATIENTS	o	Ö	14, 842, 764		71. (
	200 IMPL. DEV. CHARGED TO PATIENTS	0	0	12, 974, 948		72. (
	300 DRUGS CHARGED TO PATIENTS	0	4, 384, 725	57, 308, 686	0	73. (
	400 RENAL DI ALYSI S	0	0	252, 117	0	74.0
	550 PSYCHIATRIC/PSYCHOLOGICAL SERVICES 190 CHEMOTHERAPY	18, 257	0	5, 364, 054 5, 021, 049		76. (76. (
	330 ENDOSCOPY	2, 328	0	3, 026, 209		76. (
	950 WOUND CARE CENTER	9, 204	Ö	14, 279, 671	o	76. (
OUT	TPATIENT SERVICE COST CENTERS					
	100 EMERGENCY	61, 481	0	62, 871, 417	0	91. (
	200 OBSERVATION BEDS (NON-DISTINCT PART)					92. (
	HER REIMBURSABLE COST CENTERS 500 AMBULANCE SERVICES	0	0	8, 445, 469	0	95. (
	ECIAL PURPOSE COST CENTERS		<u> </u>	0, 110, 107	<u> </u>	70.
	300 I NTEREST EXPENSE					113. (
118. 00	SUBTOTALS (SUM OF LINES 1 through 117)	544, 744	4, 384, 725	518, 872, 850	65, 611, 647	118. (
	NREI MBURSABLE COST CENTERS	1	٦.		1	100
	000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 100 RESEARCH	0	0	0	0	190. (
	200 PHYSI CLANS' PRI VATE OFFI CES		0	0		191. (192. (
	201 MARKETI NG		ol	0	O	192. (
192. 02 19:	202 EDUCATION CENTER	0	0	0	0	192. (
	300 NONPALD WORKERS	0	0	0	0	193. (
	950 FOUNDATION	0	0	0	0	194. (
	951 ASPR BIOTERRORISM GRANT 952 CLINIC OF HOPE	0	0 3, 957	0	0	194. (194. (
200. 00	Cross Foot Adjustments		3, 737	U		200.
201.00	Negative Cost Centers					201. (
202. 00	Cost to be allocated (per Wkst. B,	3, 381, 054	3, 506, 408	107, 976	585, 289	202. (
	Part I)		, _,			
203. 00	Unit cost multiplier (Wkst. B, Part I)		0. 798966	0. 000208		203. (
204. 00	Cost to be allocated (per Wkst. B, Part II)	303, 442	113, 050	35, 197	22, 848	204. (
		0 557027	0. 025759	0. 000068	0. 000348	205. (
205.00	Unit cost multiplier (Wkst. B, Part	0. 557036	0. 0237371			

Health Fina	ncial Systems ST.	JOSEPH HOSPITAL	& HEALTH CENT	ΓFR	Inlie	u of Form CMS-	2552-10
	ATION - STATISTICAL BASIS		Provider C	CN: 15-0010	Peri od:	Worksheet B-1	
					From 07/01/2017 To 06/30/2018	Date/Time Pre	nared·
					10 00/00/2010	11/26/2018 12	
	Cost Center Description	NURSI NG	PHARMACY	MEDI CAL	ALLI ED		
		ADMI NI STRATI ON	(COSTED	RECORDS &	HEALTH-RAD		
			REQUIS.)	LI BRARY	TECH PROGRAM		
		(DI RECT NURS.		(GROSS	(RADI OLOGY		
		HRS.)		CHARGES)	CHARGES)		
		13. 00	15. 00	16.00	23. 00		
206.00	NAHE adjustment amount to be allocated	t			0		206.00
	(per Wkst. B-2)						
207. 00	NAHE unit cost multiplier (Wkst. D,				0.000000		207. 00
	Parts III and IV)						

COMPUTATION OF RATIO OF COSTS TO CHARGES Provider CCN: 15-0010 Peri od: Worksheet C From 07/01/2017 Part I Date/Time Prepared: 06/30/2018 11/26/2018 12:03 pm Title XVIII Hospi tal PPS Costs Cost Center Description Total Cost Therapy Limit Total Costs RCF Total Costs from Wkst. B, Adj Di sal I owance Part I, col. 26) 4. 00 1.00 2.00 3.00 5.00 INPATIENT ROUTINE SERVICE COST CENTERS 30 00 30 00 03000 ADULTS & PEDIATRICS 14, 780, 623 14, 780, 623 14, 780, 623 03100 INTENSIVE CARE UNIT 3, 254, 991 3, 254, 991 0 3, 254, 991 31.00 31.00 04100 SUBPROVI DER - I RF o 41.00 3,002,694 3, 002, 694 3, 002, 694 41.00 04300 NURSERY 43.00 1, 227, 483 1, 227, 483 43.00 1, 227, 483 0 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 12, 441, 836 12, 441, 836 12, 441, 836 50.00 52.00 05200 DELIVERY ROOM & LABOR ROOM 3, 353, 713 3, 353, 713 0 3, 353, 713 52.00 05400 RADI OLOGY-DI AGNOSTI C 5, 462, 848 54.00 5, 462, 848 5, 462, 848 0 54.00 54.01 03630 ULTRA SOUND 741,029 741, 029 0 741, 029 54.01 56.00 05600 RADI OI SOTOPE 2, 053, 133 2, 053, 133 13, 763 2,066,896 56.00 57.00 05700 CT SCAN 846, 191 846, 191 846, 191 57.00 0 05800 MAGNETIC RESONANCE I MAGING (MRI) 589, 187 58.00 589. 187 0 589, 187 58.00 59.00 05900 CARDIAC CATHETERIZATION 291, 990 291, 990 0 291, 990 59.00 06000 LABORATORY 7, 946, 961 7, 946, 961 60.00 7, 946, 961 0 0 0 0 0 0 60.00 2, 480, 122 06500 RESPIRATORY THERAPY 65 00 2 480 122 2 480 122 65 00 66.00 06600 PHYSI CAL THERAPY 4, 650, 551 4, 650, 551 4, 650, 551 66.00 06700 OCCUPATIONAL THERAPY 1, 714, 441 1, 714, 441 1, 714, 441 67.00 67.00 06800 SPEECH PATHOLOGY 68.00 446, 204 446, 204 446, 204 68.00 06900 ELECTROCARDI OLOGY 1, 641, 089 1, 641, 089 1, 641, 089 69 00 69 00 70.00 07000 ELECTROENCEPHALOGRAPHY 1, 131, 645 1, 131, 645 1, 131, 645 70.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 71.00 2, 543, 204 2, 543, 204 0 0 0 2, 543, 204 71.00 72 00 07200 I MPL. DEV. CHARGED TO PATIENTS 3 912 564 3, 912, 564 3, 912, 564 72 00 07300 DRUGS CHARGED TO PATIENTS 73.00 24, 769, 890 24, 769, 890 24, 769, 890 73.00 74.00 07400 RENAL DIALYSIS 381, 871 381, 871 381, 871 74.00 0 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES 76.00 2, 385, 989 2, 385, 989 2, 385, 989 76.00 03190 CHEMOTHERAPY 76 01 6, 943, 489 6, 943, 489 6, 943, 489 76 01 03330 ENDOSCOPY 0 76.02 439, 211 439, 211 439, 211 76.02 03950 WOUND CARE CENTER 1, 393, 849 1, 393, 849 1, 393, 849 76.03 76.03 OUTPATIENT SERVICE COST CENTERS 91 00 91 00 5, 235, 844 5, 235, 844 09100 EMERGENCY 5, 235, 844 0 09200 OBSERVATION BEDS (NON-DISTINCT PART) 92.00 965, 769 965, 769 965, 769 92.00 OTHER REIMBURSABLE COST CENTERS 09500 AMBULANCE SERVICES
SPECIAL PURPOSE COST CENTERS 95.00 1, 925, 955 1, 925, 955 0 1, 925, 955 95.00

118, 954, 366

117, 988, 597

965.769

Ω

118, 954, 366

117, 988, 597

965, 769

13, 763

13.763

113.00

118, 968, 129 200. 00 965, 769 201. 00

118, 002, 360 202. 00

113.00 11300 I NTEREST EXPENSE

Subtotal (see instructions)

Less Observation Beds

Total (see instructions)

200.00

201.00

					11/26/2018 12	03 pm	
			Title	XVIII	Hospi tal	PPS	
			Charges				
	Cost Center Description	I npati ent	Outpati ent	Total (col. 6	Cost or Other	TEFRA	
				+ col. 7)	Ratio	Inpati ent	
						Ratio	
		6.00	7. 00	8. 00	9. 00	10.00	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000 ADULTS & PEDIATRICS	27, 077, 483		27, 077, 483	3		30. 00
31.00	03100 INTENSIVE CARE UNIT	7, 168, 994		7, 168, 994			31. 00
41.00	04100 SUBPROVI DER - I RF	6, 022, 023		6, 022, 023	3		41.00
43.00	04300 NURSERY	4, 012, 318		4, 012, 318	3		43.00
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATI NG ROOM	27, 223, 285	58, 312, 997	85, 536, 282	0. 145457	0.000000	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	12, 182, 098	1, 289, 000	13, 471, 098	0. 248956	0.000000	52.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	2, 939, 115	21, 551, 051	24, 490, 166		0. 000000	
54. 01	03630 ULTRA SOUND	1, 226, 521	6, 977, 683			0.000000	54. 01
56. 00	05600 RADI OI SOTOPE	310, 405	18, 991, 599			0. 000000	
57. 00	05700 CT SCAN	2, 244, 711	8, 440, 386			0. 000000	
58. 00	05800 MAGNETIC RESONANCE I MAGING (MRI)	563, 751	2, 366, 424			0. 000000	
59. 00	05900 CARDI AC CATHETERI ZATI ON	475, 281	1, 312, 116			0. 000000	
60.00	06000 LABORATORY	24, 770, 993	43, 719, 963			0. 000000	60.00
65. 00	06500 RESPI RATORY THERAPY	8, 361, 343	3, 768, 688			0. 000000	
66. 00	06600 PHYSI CAL THERAPY	3, 746, 809	10, 157, 886			0. 000000	
67. 00	06700 OCCUPATI ONAL THERAPY	2, 871, 519	1, 717, 989			0. 000000	
68. 00	06800 SPEECH PATHOLOGY	563, 804	450, 468			0. 000000	
69. 00	06900 ELECTROCARDI OLOGY	2, 508, 496	12, 107, 784			0. 000000	69.00
70. 00	07000 ELECTROENCEPHALOGRAPHY	200, 110	6, 544, 799			0. 000000	
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	8, 471, 178	6, 371, 586			0. 000000	
72. 00	07200 IMPL. DEV. CHARGED TO PATIENTS	8, 509, 520	4, 465, 428			0. 000000	
73. 00	07300 DRUGS CHARGED TO PATIENTS	11, 031, 722	46, 276, 964			0. 000000	
74. 00	07400 RENAL DIALYSIS	252, 117	40, 270, 704			0. 000000	
76.00	03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	21, 177	5, 342, 877			0. 000000	
76. 00	03190 CHEMOTHERAPY	143, 762	4, 877, 287			0. 000000	
76. 01	03330 ENDOSCOPY	l l					76. 01
76. 02	03950 WOUND CARE CENTER	273, 887	2, 752, 322			0. 000000 0. 000000	
76.03	OUTPATIENT SERVICE COST CENTERS	161, 971	14, 117, 700	14, 279, 67	0. 097611	0.000000	76.03
01 00	09100 EMERGENCY	10 074 0/5	51, 997, 352	(2.071.41	0. 083279	0.000000	01 00
91.00		10, 874, 065					
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	388, 400	1, 920, 174	2, 308, 574	0. 418340	0. 000000	92. 00
05.00	OTHER REIMBURSABLE COST CENTERS		0.445.440	0.445.47	0.000047	0.00000	05.00
95. 00	09500 AMBULANCE SERVICES	0	8, 445, 469	8, 445, 469	0. 228046	0. 000000	95. 00
	SPECIAL PURPOSE COST CENTERS						
	11300 INTEREST EXPENSE	474 504 650	044 075 000	F40 070 05			113. 00
200.00	, ,	174, 596, 858	344, 275, 992	518, 872, 850	ן		200. 00
201.00		474 504 650	044 075 000	F40 070 05			201. 00
202.00	Total (see instructions)	174, 596, 858	344, 275, 992	518, 872, 850	וי		202. 00

Health Financial Systems

ST. JOSEPH HOSPITAL & HEALTH CENTER

In Lieu of Form CMS-2552-10

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 15-0010

Period:
From 07/01/2017
To 06/30/2018

Date/Time Prepared:

			10 06/30/2018	Date/lime Prepared: 11/26/2018 12:03 pm
		Title XVIII	Hospi tal	PPS
Cost Center Description	PPS Inpatient			
	Ratio			
	11. 00			
I NPATI ENT ROUTI NE SERVI CE COST CENTERS				
30. 00 03000 ADULTS & PEDI ATRI CS				30.00
31.00 03100 INTENSIVE CARE UNIT				31.00
41. 00 04100 SUBPROVI DER - I RF				41. 00
43. 00 04300 NURSERY				43. 00
ANCILLARY SERVICE COST CENTERS				
50.00 05000 OPERATING ROOM	0. 145457			50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0. 248956			52. 00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 223063			54.00
54. 01 03630 ULTRA SOUND	0. 090323			54. 01
56. 00 05600 RADI 0I SOTOPE	0. 107082			56. 00
57. 00 05700 CT SCAN	0. 079194			57. 00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0. 201076			58. 00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0. 163360			59. 00
60. 00 06000 LABORATORY	0. 116029			60.00
65. 00 06500 RESPIRATORY THERAPY	0. 204461			65. 00
66. 00 06600 PHYSI CAL THERAPY	0. 334459			66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	0. 373557			67. 00
68. 00 06800 SPEECH PATHOLOGY	0. 439925			68. 00
69. 00 06900 ELECTROCARDI OLOGY	0. 112278			69. 00
70. 00 07000 ELECTROENCEPHALOGRAPHY	0. 167778			70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 171343			71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 301548			72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 432219			73. 00
74. 00 07400 RENAL DI ALYSI S	1. 514658			74. 00
76. 00 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	0. 444811			76. 00
76. 01 03190 CHEMOTHERAPY	1. 382876			76. 01
76. 02 03330 ENDOSCOPY	0. 145136			76. 02
76. 03 03950 WOUND CARE CENTER	0. 097611			76. 03
OUTPATIENT SERVICE COST CENTERS				
91. 00 09100 EMERGENCY	0. 083279			91. 00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 418340			92. 00
OTHER REIMBURSABLE COST CENTERS				
95. 00 09500 AMBULANCE SERVICES	0. 228046			95. 00
SPECIAL PURPOSE COST CENTERS				
113. 00 11300 I NTEREST EXPENSE				113. 00
200.00 Subtotal (see instructions)				200. 00
201.00 Less Observation Beds				201. 00
202.00 Total (see instructions)				202. 00

Heal th	n Financial Systems ST.	JOSEPH HOSPITAL	_ & HEALTH CENT	ΓER	In Lie	u of Form CMS-2	2552-10
COMPU	TATION OF RATIO OF COSTS TO CHARGES		Provi der C	CN: 15-0010	Peri od:	Worksheet C	
					From 07/01/2017	Part I	
					To 06/30/2018		pared:
				VI V		11/26/2018 12	:03 pm
			liti	e XIX	Hospi tal	Cost	
					Costs	T	
	Cost Center Description	Total Cost	Therapy Limit	Total Costs	RCE	Total Costs	
		(from Wkst. B,	Adj .		Di sal I owance		
		Part I, col.					
		26)					
	LAURATI ENT. DOUTLAIE OFFICE COOT OFFITEDO	1. 00	2. 00	3.00	4. 00	5. 00	
	I NPATI ENT ROUTI NE SERVI CE COST CENTERS	11.700 (00		1 1 700 (0	ما ما	11 700 (00	
30. 00		14, 780, 623		14, 780, 62		14, 780, 623	
31. 00		3, 254, 991		3, 254, 99		3, 254, 991	
41. 00	04100 SUBPROVI DER - I RF	3, 002, 694		3, 002, 69		3, 002, 694	
43.00		1, 227, 483		1, 227, 48	3 0	1, 227, 483	43.00
	ANCILLARY SERVICE COST CENTERS				-		
50.00		12, 441, 836		12, 441, 83	6 0	12, 441, 836	
52.00		3, 353, 713		3, 353, 71	3 0	3, 353, 713	52. 00
54.00	05400 RADI OLOGY-DI AGNOSTI C	5, 462, 848		5, 462, 84	8 0	5, 462, 848	54.00
54. 01	03630 ULTRA SOUND	741, 029		741, 02	9 0	741, 029	54. 01
56.00	05600 RADI OI SOTOPE	2, 053, 133		2, 053, 13	3 13, 763	2, 066, 896	56.00
57.00	05700 CT SCAN	846, 191		846, 19	1 0	846, 191	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	589, 187		589, 18	7 o	589, 187	58. 00
59. 00		291, 990		291, 99	ol ol	291, 990	59.00
60.00	06000 LABORATORY	7, 946, 961		7, 946, 96	1 0	7, 946, 961	60.00
65.00	06500 RESPI RATORY THERAPY	2, 480, 122	o	2, 480, 12	2 0	2, 480, 122	
66.00	06600 PHYSI CAL THERAPY	4, 650, 551	0	4, 650, 55		4, 650, 551	
67.00		1, 714, 441	Ó	1, 714, 44		1, 714, 441	
68. 00	1	446, 204	0	446, 20		446, 204	
69. 00		1, 641, 089	_	1, 641, 08		1, 641, 089	
70.00		1, 131, 645		1, 131, 64		1, 131, 645	
71.00		2, 543, 204		2, 543, 20		2, 543, 204	
71.00		3, 912, 564		3, 912, 56	1 1	3, 912, 564	
73. 00	1	24, 769, 890		24, 769, 89		24, 769, 890	
74. 00	+ I	381, 871		381, 87		381, 871	1
76. 00		2, 385, 989		2, 385, 98		2, 385, 989	
76. 01	03190 CHEMOTHERAPY	6, 943, 489		6, 943, 48		6, 943, 489	
76. 02		439, 211		439, 21		439, 211	
76. 03	03950 WOUND CARE CENTER	1, 393, 849		1, 393, 84	9 0	1, 393, 849	76. 03
	OUTPATIENT SERVICE COST CENTERS			T 5 005 04		5 005 044	
91. 00		5, 235, 844		5, 235, 84		.,	
92. 00		965, 769		965, 76	9	965, 769	92. 00
	OTHER REIMBURSABLE COST CENTERS			1	1		
95. 00		1, 925, 955		1, 925, 95	5 0	1, 925, 955	95. 00
	SPECIAL PURPOSE COST CENTERS						
112 0	11200 INTEREST EVRENCE	1	1	1	1		1112 00

118, 954, 366

965, 769 117, 988, 597 118, 954, 366

965, 769 117, 988, 597 118, 968, 129 200. 00 965, 769 201. 00 118, 002, 360 202. 00

13, 763

13, 763

113. 00 11300 INTEREST EXPENSE
200. 00 Subtotal (see instructions)

Less Observation Beds

Total (see instructions)

201.00

Health Financial Systems ST. JOSEPH HOSPITAL & HEALTH CENTER In Lieu of Form CMS-2552-10 COMPUTATION OF RATIO OF COSTS TO CHARGES Provider CCN: 15-0010 Peri od: Worksheet C From 07/01/2017 Part I Date/Time Prepared: 06/30/2018 11/26/2018 12:03 pm Title XIX Hospi tal Cost Charges Cost Center Description Inpati ent Outpati ent Total (col. 6 Cost or Other TFFRA I npati ent + col . 7) Ratio Ratio 6.00 7.00 8.00 9. 00 10.00 INPATIENT ROUTINE SERVICE COST CENTERS 03000 ADULTS & PEDIATRICS 27. 077. 483 27, 077, 483 30.00 30.00 31.00 03100 INTENSIVE CARE UNIT 7, 168, 994 7, 168, 994 31.00 04100 SUBPROVI DER - I RF 6, 022, 023 6, 022, 023 41.00 41.00 4, 012, 318 43.00 04300 NURSERY 4<u>, 012, 318</u> 43.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 27, 223, 285 58, 312, 997 85, 536, 282 0.145457 0.000000 50.00 52 00 05200 DELIVERY ROOM & LABOR ROOM 12, 182, 098 1, 289, 000 13, 471, 098 0. 248956 0.000000 52.00 05400 RADI OLOGY-DI AGNOSTI C 2, 939, 115 24, 490, 166 0. 223063 54.00 21, 551, 051 0.000000 54.00 03630 ULTRA SOUND 8, 204, 204 0.090323 0.000000 54.01 1, 226, 521 6, 977, 683 54 01 56.00 05600 RADI OI SOTOPE 310, 405 18, 991, 599 19, 302, 004 0.106369 0.000000 56.00 57.00 05700 CT SCAN 2, 244, 711 8, 440, 386 10, 685, 097 0.079194 0.000000 57.00 05800 MAGNETIC RESONANCE IMAGING (MRI) 2, 930, 175 0. 201076 0.000000 58.00 563, 751 2, 366, 424 58.00 05900 CARDIAC CATHETERIZATION 59.00 475, 281 1, 312, 116 1, 787, 397 0.163360 0.000000 59.00 60.00 06000 LABORATORY 24, 770, 993 43, 719, 963 68, 490, 956 0.116029 0.000000 60.00 65.00 06500 RESPIRATORY THERAPY 8, 361, 343 3, 768, 688 12, 130, 031 0.204461 0.000000 65.00 10, 157, 886 06600 PHYSI CAL THERAPY 3, 746, 809 13, 904, 695 0.334459 0.000000 66.00 66,00

Health Financial Systems

ST. JOSEPH HOSPITAL & HEALTH CENTER

In Lieu of Form CMS-2552-10

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 15-0010

Period:
From 07/01/2017
To 06/30/2018

Date/Time Prepared:

			To 06/30/2018	Date/Time Prepared: 11/26/2018 12:03 pm
		Title XIX	Hospi tal	Cost
Cost Center Description	PPS Inpatient			
	Ratio			
	11. 00			
INPATIENT ROUTINE SERVICE COST CENTERS				
30. 00 03000 ADULTS & PEDI ATRI CS				30.00
31.00 03100 INTENSIVE CARE UNIT				31.00
41. 00 04100 SUBPROVI DER - I RF				41.00
43. 00 04300 NURSERY				43. 00
ANCILLARY SERVICE COST CENTERS				
50.00 05000 OPERATING ROOM	0. 000000			50.00
52.00 O5200 DELIVERY ROOM & LABOR ROOM	0. 000000			52. 00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 000000			54. 00
54. 01 03630 ULTRA SOUND	0. 000000			54. 01
56. 00 05600 RADI OI SOTOPE	0. 000000			56. 00
57. 00 05700 CT SCAN	0. 000000			57.00
58.00 05800 MAGNETIC RESONANCE I MAGING (MRI)	0. 000000			58. 00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0. 000000			59. 00
60. 00 06000 LABORATORY	0. 000000			60.00
65. 00 06500 RESPIRATORY THERAPY	0. 000000			65. 00
66. 00 06600 PHYSI CAL THERAPY	0. 000000			66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	0. 000000			67. 00
68.00 06800 SPEECH PATHOLOGY	0. 000000			68. 00
69. 00 06900 ELECTROCARDI OLOGY	0. 000000			69. 00
70. 00 07000 ELECTROENCEPHALOGRAPHY	0. 000000			70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 000000			71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 000000			72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 000000			73. 00
74.00 07400 RENAL DIALYSIS	0. 000000			74. 00
76. 00 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	0. 000000			76. 00
76. 01 03190 CHEMOTHERAPY	0. 000000			76. 01
76. 02 03330 ENDOSCOPY	0. 000000			76. 02
76.03 03950 WOUND CARE CENTER	0. 000000			76. 03
OUTPATIENT SERVICE COST CENTERS				
91. 00 09100 EMERGENCY	0. 000000			91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 000000			92. 00
OTHER REIMBURSABLE COST CENTERS				
95. 00 09500 AMBULANCE SERVICES	0. 000000			95. 00
SPECIAL PURPOSE COST CENTERS				
113. 00 11300 I NTEREST EXPENSE				113. 00
200.00 Subtotal (see instructions)				200. 00
201.00 Less Observation Beds				201. 00
202.00 Total (see instructions)				202. 00

Health Financial Systems ST.	JOSEPH HOSPITA	L & HEALTH CEN	TER	In Li∈	eu of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL	_ COSTS		1	Period: From 07/01/2017 To 06/30/2018	Date/Time Pre 11/26/2018 12	pared:
			XVIII	Hospi tal	PPS	
Cost Center Description	Capi tal	Swing Bed	Reduced		Per Diem (col.	
	Related Cost	Adjustment	Capi tal	Days	3 / col . 4)	
	(from Wkst. B,		Related Cost			
	Part II, col.		(col . 1 - col			
	26)		2)			
	1.00	2. 00	3. 00	4. 00	5. 00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 ADULTS & PEDI ATRI CS	917, 542		917, 54			
31.00 INTENSIVE CARE UNIT	173, 698		173, 69	·	l .	
41. 00 SUBPROVI DER - I RF	234, 554	· C	234, 55	4 3, 547	66. 13	41. 00
43. 00 NURSERY	75, 190)	75, 19	2, 162	34. 78	43.00
200.00 Total (lines 30 through 199)	1, 400, 984		1, 400, 98	4 23, 300	,	200. 00
Cost Center Description	I npati ent	I npati ent				
	Program days	Program				
		Capital Cost				
		(col. 5 x col.				
		6)				
	6. 00	7. 00				
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 ADULTS & PEDI ATRI CS	5, 581					30. 00
31.00 INTENSIVE CARE UNIT	1, 318					31. 00
41. 00 SUBPROVI DER - I RF	2, 475	163, 672	2			41.00
43. 00 NURSERY	0) C)			43.00
200.00 Total (lines 30 through 199)	9, 374	614, 550)			200. 00

		JOSEPH JOSEPH TA	L A LIEALTH OFNE	TED.		6.5	0550 40
Heal th Financ	T OF INPATIENT ANCILLARY SERVICE CAPITA	JOSEPH HOSPITA IL COSTS	Provider C	CN: 15-0010	Period: From 07/01/2017 To 06/30/2018		pared:
			Title	xVIII	Hospi tal	PPS	. 00 p
	Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cos to Charges	t Inpatient Program	Capital Costs (column 3 x column 4)	
		1.00	2.00	3.00	4. 00	5. 00	
	ARY SERVICE COST CENTERS		T				
	OPERATING ROOM	1, 012, 550		1			
	DELIVERY ROOM & LABOR ROOM	183, 937				l e	
	RADI OLOGY-DI AGNOSTI C	752, 659				48, 415	
	ULTRA SOUND	23, 909					
	RADI OI SOTOPE	90, 278					
	CT SCAN	20, 039		1			
	MAGNETIC RESONANCE IMAGING (MRI)	13, 383					
	CARDI AC CATHETERI ZATI ON	27, 768		1			
	LABORATORY RESPI RATORY THERAPY	252, 098				40, 844 38, 587	
	PHYSICAL THERAPY	124, 768 219, 795					
	OCCUPATIONAL THERAPY	84, 900					
	SPEECH PATHOLOGY	24, 370			· ·		
	ELECTROCARDI OLOGY	229, 018			· ·		1
	ELECTROCARDIOLOGI	79, 285					1
	MEDICAL SUPPLIES CHARGED TO PATIENTS	180, 118					
	IMPL. DEV. CHARGED TO PATIENTS	81, 156		1			
	DRUGS CHARGED TO PATIENTS	553, 577					
	RENAL DIALYSIS	7, 999					
	PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	104, 020			· ·	0	1
	CHEMOTHERAPY	153, 606		1			
	ENDOSCOPY	89, 829		1		l e	
76. 03 03950	WOUND CARE CENTER	73, 599				0	
OUTDAT	TENT CEDVICE COCT CENTEDS	•		•			1

421, 178

59, 952

4, 863, 791

62, 871, 417

466, 146, 563

2, 308, 574

0.006699

0.025969

5, 737, 571

57, 070, 230

269, 212

91.00

92.00

95.00

38, 436

6, 991

551, 374 200. 00

09100 EMERGENCY

95. 00 09500 AMBULANCE SERVICES

91.00

92.00

200.00

OUTPATIENT SERVICE COST CENTERS

09200 OBSERVATION BEDS (NON-DISTINCT PART)
OTHER REIMBURSABLE COST CENTERS

Total (lines 50 through 199)

Health Financial Systems ST.	JOSEPH HOSPI TAL	. & HEALTH CENT	ΓER	In Lie	eu of Form CMS-	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PA	ASS THROUGH COST	S Provider Co		Period: From 07/01/2017 To 06/30/2018		pared: :03 pm
		Title	: XVIII	Hospi tal	PPS	
Cost Center Description	Nursing School	Nursing School	Allied Health	Allied Health	All Other	
	Post-Stepdown		Post-Stepdown		Medi cal	
	Adjustments		Adjustments		Education Cost	
	1A	1. 00	2A	2. 00	3. 00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDIATRICS	0	0		0 0	0	30.00
31.00 03100 INTENSIVE CARE UNIT	0	0		0	0	31.00
41. 00 04100 SUBPROVI DER - I RF	0	0		0	0	41.00
43. 00 04300 NURSERY	0	0		0	0	43.00
200.00 Total (lines 30 through 199)	0	0		0	0	200.00

Cost Center Description	Nursing School	Nursing School	Allied Health		All Other	
	Post-Stepdown		Post-Stepdown	Cost	Medi cal	
	Adjustments		Adjustments		Education Cost	
	1A	1.00	2A	2. 00	3. 00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDIATRICS	0	0	0	0	0	30. 00
31.00 03100 INTENSIVE CARE UNIT	0	0	0	0	0	31. 00
41. 00 04100 SUBPROVI DER - 1 RF	0	0	0	0	0	41. 00
43. 00 04300 NURSERY	0	0	0	0	0	43.00
200.00 Total (lines 30 through 199)	0	0	0	0	0	200. 00
Cost Center Description	Swi ng-Bed	Total Costs	Total Patient	Per Diem (col.	Inpati ent	
'	Adjustment	(sum of cols.	Days	5 ÷ col . 6)	Program Days	
	Amount (see	1 through 3,	·			
	instructions)	minus col. 4)				
	4.00	5.00	6.00	7. 00	8. 00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDIATRICS	0	0	15, 779	0.00	5, 581	30.00
31.00 03100 INTENSIVE CARE UNIT		0	1, 812	0.00	1, 318	31.00
41. 00 04100 SUBPROVI DER - RF	0	0	3, 547	0.00	2, 475	41.00
43. 00 04300 NURSERY		0	2, 162	0.00	0	43. 00
200.00 Total (lines 30 through 199)		0	23, 300		9, 374	200. 00
Cost Center Description	I npati ent					
	Program					
	Pass-Through					
	Cost (col. 7 x					
	col. 8)					
	9. 00					
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDI ATRI CS	0)				30. 00
31.00 03100 INTENSIVE CARE UNIT	0					31. 00
41. 00 04100 SUBPROVI DER - RF	0					41. 00
43. 00 04300 NURSERY	0					43. 00
200.00 Total (lines 30 through 199)	0					200. 00
	•	•				•

| In Lieu of Form CMS-2552-10 | Peri od: | Worksheet D | From 07/01/2017 | Part IV | To 06/30/2018 | Date/Time Prepared: | THROUGH COSTS

					10 00/00/2010	11/26/2018 12	
				: XVIII	Hospi tal	PPS	
	Cost Center Description	Non Physician	Nursing School	Nursing Schoo	Allied Health	Allied Health	
			Post-Stepdown		Post-Stepdown		
		Cost	Adjustments		Adjustments		
		1.00	2A	2. 00	3A	3. 00	
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATI NG ROOM	0	0		0	0	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0		0	0	52.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0	0		0	218, 444	54. 00
54. 01	03630 ULTRA SOUND	0	0		0	73, 190	1
56.00	05600 RADI OI SOTOPE	0	0		0	172, 193	56. 00
57.00	05700 CT SCAN	0	0		0	95, 322	57.00
58. 00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0		0	26, 140	58. 00
59. 00	05900 CARDI AC CATHETERI ZATI ON	0	0		0	0	59. 00
60.00	06000 LABORATORY	0	0		0	0	60.00
65.00	06500 RESPI RATORY THERAPY	0	0		0	0	65. 00
66.00	06600 PHYSI CAL THERAPY	0	0		0	0	66. 00
67.00	06700 OCCUPATI ONAL THERAPY	0	0		0	0	67. 00
68.00	06800 SPEECH PATHOLOGY	0	0		0	0	68. 00
69.00	06900 ELECTROCARDI OLOGY	0	0		0	0	69. 00
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0		0	0	70. 00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		0	0	71. 00
72.00	07200 I MPL. DEV. CHARGED TO PATIENTS	0	0		0	0	72. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0		0	0	73. 00
74.00	07400 RENAL DIALYSIS	0	0		0	0	74. 00
76.00	03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	0	0		0	0	76. 00
76. 01	03190 CHEMOTHERAPY	0	0		0	0	76. 01
76. 02	03330 ENDOSCOPY	0	0		0	0	76. 02
76. 03	03950 WOUND CARE CENTER	0	0		0	0	76. 03
	OUTPATIENT SERVICE COST CENTERS						
91.00	09100 EMERGENCY	0	0		0 0	0	91. 00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0			0	0	92.00
	OTHER REIMBURSABLE COST CENTERS						
95.00	09500 AMBULANCE SERVI CES						95. 00
200.00	Total (lines 50 through 199)	0	0		0	585, 289	200. 00
		•					

THROUGH COSTS

			1	0 06/30/2018	11/26/2018 12	
		Title	XVIII	Hospi tal	PPS	
Cost Center Description	All Other	Total Cost	Total	Total Charges	Ratio of Cost	
	Medi cal	(sum of col 1	Outpati ent	(from Wkst. C,	to Charges	
	Education Cost	through col.	Cost (sum of		$(col. 5 \div col.$	
		4)	col. 2, 3 and	8)	7)	
	4.00	5. 00	4) 6. 00	7. 00	8. 00	
ANCILLARY SERVICE COST CENTERS	4.00	3.00	0.00	7.00	0.00	
50. 00 05000 OPERATING ROOM	O	0	0	85, 536, 282	0. 000000	50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	o	0	l o		0. 000000	
54. 00 05400 RADI OLOGY-DI AGNOSTI C	O	218, 444	218, 444		0. 008920	
54. 01 03630 ULTRA SOUND	O	73, 190	73, 190	8, 204, 204	0. 008921	54. 01
56. 00 05600 RADI 0I SOTOPE	0	172, 193	172, 193	19, 302, 004	0. 008921	56.00
57.00 05700 CT SCAN	O	95, 322	95, 322	10, 685, 097	0. 008921	57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	O	26, 140	26, 140	2, 930, 175	0. 008921	58. 00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0	0	0	1, 787, 397	0.000000	59. 00
60. 00 06000 LABORATORY	0	0	0	68, 490, 956	0.000000	60.00
65. 00 06500 RESPIRATORY THERAPY	0	0	0	12, 130, 031	0.000000	65. 00
66. 00 06600 PHYSI CAL THERAPY	0	0	0	13, 904, 695	0.000000	66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	0	0	0	4, 589, 508	0.000000	67. 00
68. 00 06800 SPEECH PATHOLOGY	0	0	0	1, 014, 272	0.000000	68. 00
69. 00 06900 ELECTROCARDI OLOGY	0	0	0	14, 616, 280	0.000000	
70. 00 07000 ELECTROENCEPHALOGRAPHY	0	0	0	6, 744, 909	0.000000	
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	14, 842, 764	0.000000	
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0		0.000000	
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0	0	57, 308, 686	0.000000	73. 00
74. 00 07400 RENAL DI ALYSI S	0	0	0	252, 117	0. 000000	
76. 00 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	0	0	0	5, 364, 054	0. 000000	
76. 01 03190 CHEMOTHERAPY	0	0	0	5, 021, 049		
76. 02 03330 ENDOSCOPY	0	0	0	3, 026, 209	0. 000000	
76. 03 03950 WOUND CARE CENTER	0	0	0	14, 279, 671	0. 000000	76. 03
OUTPATIENT SERVICE COST CENTERS			,			
91. 00 09100 EMERGENCY	0	0			0. 000000	1
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	2, 308, 574	0. 000000	92.00
OTHER REIMBURSABLE COST CENTERS						
95. 00 09500 AMBULANCE SERVICES		F0F 000	505 000	4// 44/ 5/0		95.00
200.00 Total (lines 50 through 199)	0	585, 289	585, 289	466, 146, 563		200. 00

	Financial Systems ST. TONMENT OF INPATIENT/OUTPATIENT ANCILLARY SER	JOSEPH HOSPITAL	& HEALTH CENT		ln Li∈ Period:	eu of Form CMS-2 Worksheet D	2552-10
	TONMENT OF INPATTENT/OUTPATTENT ANCILLARY SER H COSTS	VICE UIHER PASS	Provider Co		Period: From 07/01/2017	Part IV	
TTIKOOC	11 60313				To 06/30/2018	Date/Time Pre	pared:
						11/26/2018 12	:03 pm
				XVIII	Hospi tal	PPS	
	Cost Center Description	Outpati ent	Inpatient	Inpatient	Outpati ent	Outpati ent	
		Ratio of Cost	Program	Program	Program	Program	
		to Charges	Charges	Pass-Through		Pass-Through	
		(col. 6 ÷ col.		Costs (col. 8	5	Costs (col. 9	
		7)	10.00	x col. 10) 11.00	12.00	x col . 12) 13.00	
	ANCILLARY SERVICE COST CENTERS	9.00	10.00	11.00	12.00	13.00	
50. 00	05000 OPERATING ROOM	0. 000000	14, 009, 280		0 18, 764, 076	0	50.00
52. 00	05200 DELIVERY ROOM & LABOR ROOM	0. 000000	55, 359		0 4, 290	l e	52.00
54. 00	05400 RADI OLOGY-DI AGNOSTI C	0. 000000	1, 575, 331	14, 05	,	58, 632	
54. 00	03630 ULTRA SOUND	0. 008920	455, 878			19, 750	
56. 00	05600 RADI OI SOTOPE	0. 008921	123, 859				1
57. 00	05700 CT SCAN	0. 008921	1, 111, 992				
58. 00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0. 008921	278, 350			7, 056	
59. 00	05900 CARDI AC CATHETERI ZATI ON	0.000000	214, 803		0 770, 704	7,030	59.00
60.00	06000 LABORATORY	0. 000000	11, 095, 956		0 7, 551, 148		60.00
65. 00	06500 RESPIRATORY THERAPY	0.000000	3, 751, 411		0 1, 249, 081	0	65.00
66. 00	06600 PHYSI CAL THERAPY	0. 000000	1, 144, 279		0 77, 866		66.00
67. 00	06700 OCCUPATI ONAL THERAPY	0. 000000	829, 145		0 41, 467	0	67.00
68. 00	06800 SPEECH PATHOLOGY	0. 000000	228, 928		0 17, 402	0	68.00
69. 00	06900 ELECTROCARDI OLOGY	0. 000000	1, 809, 176		0 6, 161, 196		69.00
70. 00	07000 ELECTROENCEPHALOGRAPHY	0. 000000	1, 804, 176		0 1, 967, 353		70.00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 000000	3, 587, 463		0 2, 470, 000	l	71.00
71.00	07200 I MPL. DEV. CHARGED TO PATIENTS	0. 000000	5, 417, 752		0 1, 623, 209		72.00
73. 00	07300 DRUGS CHARGED TO PATIENTS	0. 000000	4, 936, 898		0 18, 335, 618	l e	73.00
74. 00	07400 RENAL DIALYSIS	0. 000000	146, 665		0 10, 333, 010		74.00
76. 00	03550 PSYCHIATRI C/PSYCHOLOGI CAL SERVI CES	0. 000000	140, 000			0	76.00
76. 00	03190 CHEMOTHERAPY	0. 000000	7, 558		0 0 1, 127, 110		76. 00
76. 01	03330 ENDOSCOPY	0. 000000	128, 378		0 719, 810	l e	76. 01
76. 02	03950 WOUND CARE CENTER	0. 000000	120, 370		0 7, 783, 726		76. 02
10.03	OUTDATIENT SERVICE COST CENTERS	0.000000			0, 1,103,120	10	, 0.03

0.000000

0.000000

5, 737, 571 269, 212

57, 070, 230

0

0

31, 627

14, 328, 185

104, 482, 748

437, 671

0

0

194, 681 200. 00

91.00

92.00

95.00

03950 WOUND CARE CENTER
OUTPATIENT SERVICE COST CENTERS

09200 OBSERVATION BEDS (NON-DISTINCT PART)
OTHER REIMBURSABLE COST CENTERS

Total (lines 50 through 199)

09100 EMERGENCY

95. 00 09500 AMBULANCE SERVICES

91.00

92.00

Health Financial Systems	ST. JOSEPH HOSPITAL &	HEALTH CENTER	In Lieu	u of Form CMS-2552-10
ADDODEL ONNENT OF MEDICAL	OTHER HEALTH OFFILE OF AND MAGNINE COOT	D 1 1 00N 45 0040	5	

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST Provider CCN: 15-0010 Peri od: Worksheet D From 07/01/2017 Part V 06/30/2018 Date/Time Prepared: 11/26/2018 12:03 pm Title XVIII Hospi tal Charges Costs Cost to Charge PPS Reimbursed Cost Center Description Cost Cost PPS Services Ratio From Services (see Rei mbursed Rei mbursed (see inst.) Worksheet C, inst.) Servi ces Services Not Part I, col. 9 Subject To Subject To Ded. & Coins. Ded. & Coins. (see inst.) (see inst.) 1.00 2.00 5. 00 3.00 4.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 0. 145457 18, 764, 076 2, 729, 366 50.00 52.00 05200 DELIVERY ROOM & LABOR ROOM 0. 248956 4, 290 0 0 1,068 52.00 05400 RADI OLOGY-DI AGNOSTI C 6, 573, 131 0 0 54 00 0.223063 54 00 1, 466, 222 0 0 54.01 03630 ULTRA SOUND 0.090323 2, 213, 831 199, 960 54.01 56.00 05600 RADI 0I S0T0PE 0.106369 9, 162, 598 974, 616 56.00 57.00 05700 CT SCAN 0.079194 3.082.996 0 0 244, 155 57.00 05800 MAGNETIC RESONANCE I MAGING (MRI) 0 58.00 0.201076 790, 984 159, 048 58.00 59.00 05900 CARDI AC CATHETERI ZATI ON 0.163360 0 59.00 0 60.00 06000 LABORATORY 0.116029 7, 551, 148 0 876, 152 60.00 0 06500 RESPIRATORY THERAPY 1, 249, 081 255, 388 65 00 0 204461 65 00 66.00 06600 PHYSI CAL THERAPY 0.334459 77, 866 26,043 66.00 06700 OCCUPATIONAL THERAPY 0.373557 41, 467 0 0 15, 490 67.00 67.00 0 06800 SPEECH PATHOLOGY 0.439925 17, 402 0 68.00 7.656 68.00 0 691, 767 06900 FLECTROCARDLOLOGY 0.112278 69 00 6, 161, 196 69 00 70.00 07000 ELECTROENCEPHALOGRAPHY 0. 167778 1, 967, 353 0 0 330, 079 70.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0. 171343 2, 470, 000 0 71.00 423, 217 71.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0. 301548 0 ol 489, 475 72.00 1, 623, 209 72.00 07300 DRUGS CHARGED TO PATIENTS 0 73.00 0.432219 18, 335, 618 6, 383 7, 925, 002 73.00 74.00 07400 RENAL DIALYSIS 1.514658 74.00 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES 0 76.00 0.444811 0 0 76.00 1, 127, 110 03190 CHEMOTHERAPY 0 76.01 1. 382876 0 1, 558, 653 76.01 03330 ENDOSCOPY 0 76.02 0.145136 719, 810 0 104, 470 76 02 03950 WOUND CARE CENTER 0.097611 7, 783, 726 0 759, 777 76.03 76.03 OUTPATIENT SERVICE COST CENTERS 14, 328, 185 1, 193, 237 91.00 09100 EMERGENCY 0.083279 91.00 0 09200 OBSERVATION BEDS (NON-DISTINCT PART) 0 91 92.00 0.418340 437, 671 183, 095 92.00 OTHER REIMBURSABLE COST CENTERS 95.00 09500 AMBULANCE SERVICES 0. 228046 0 95.00 6, 474 200.00 Subtotal (see instructions) 0 20, 613, 936 200. 00 104, 482, 748 0 201.00 Less PBP Clinic Lab. Services-Program 201.00 Only Charges 202.00 Net Charges (line 200 - line 201) 104, 482, 748 0 6, 474 20, 613, 936 202. 00

				From 07/01/2017 To 06/30/2018	Part V Date/Time Pre 11/26/2018 12	epared: 2:03 pm
		Title	XVIII	Hospi tal	PPS	
	Cost	S				
Cost Center Description	Cost	Cost				
	Rei mbursed	Rei mbursed				
		Services Not				
		Subject To				
		ed. & Coins.				
		(see inst.)				
	6. 00	7. 00				
ANCI LLARY SERVI CE COST CENTERS			I			
50. 00 05000 OPERATI NG ROOM	0	0				50.00
52. 00 05200 DELIVERY ROOM & LABOR ROOM	0	0				52. 00
54. 00 05400 RADI OLOGY - DI AGNOSTI C	0	0				54. 00
54. 01 03630 ULTRA SOUND	0	0				54. 01
56. 00 05600 RADI 01 SOTOPE	0	0				56. 00
57. 00 05700 CT SCAN	0	0				57. 00
58. 00 05800 MAGNETIC RESONANCE I MAGING (MRI)	0	0				58. 00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0	0				59. 00
60. 00 06000 LABORATORY	0	0				60. 00
65. 00 06500 RESPI RATORY THERAPY	0	0				65. 00
66. 00 06600 PHYSI CAL THERAPY	0	0				66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	0	0				67. 00
68. 00 06800 SPEECH PATHOLOGY	0	0				68. 00
69. 00 06900 ELECTROCARDI OLOGY	0	0				69. 00
70. 00 07000 ELECTROENCEPHALOGRAPHY	0	0				70.00
71. 00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS	0	0				71. 00
72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	ı			72. 00
73. 00 07300 DRUGS CHARGED TO PATIENTS	0	2, 759	i			73. 00
74. 00 07400 RENAL DIALYSIS	0	0				74. 00 76. 00
76. 00 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES 76. 01 03190 CHEMOTHERAPY	0	0				
76. 01 03190 CHEMOTHERAPY 76. 02 03330 ENDOSCOPY		0				76. 01 76. 02
76. 02 03330 ENDOSCOPT 76. 03 03950 WOUND CARE CENTER		0				76. 02
OUTPATIENT SERVICE COST CENTERS	J U					70.03
91. 00 09100 EMERGENCY	0	0				91.00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)		38				92. 00
OTHER REIMBURSABLE COST CENTERS	<u> </u>	30	l			72.00
95. 00 09500 AMBULANCE SERVICES	0					95. 00
200.00 Subtotal (see instructions)		2, 797				200. 00
201.00 Less PBP Clinic Lab. Services-Program		2, 171				201. 00
Only Charges						
202.00 Net Charges (line 200 - line 201)	o	2, 797				202. 00

	JOSEPH HOSPITA			In Lie	eu of Form CMS-	2552-10
APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITA	AL COSTS	Provi der C	CN: 15-0010	Peri od:	Worksheet D	
		Component		From 07/01/2017 To 06/30/2018	Part II Date/Time Pre 11/26/2018 12	
		Ti tl e	XVIII	Subprovi der -	PPS	
	_			I RF		
Cost Center Description	Capi tal	Total Charges			Capital Costs	
		(from Wkst. C,		Program	(column 3 x	
	(from Wkst. B,	Part I, col.		. Charges	column 4)	
	Part II, col.	8)	2)			
	26)	2.00	2.00	4.00	F 00	
ANCILLARY CERVICE COCT CENTERS	1. 00	2. 00	3. 00	4. 00	5. 00	
ANCILLARY SERVICE COST CENTERS	1 012 550	05 524 202	0.01103	0	//5	FO 00
50. 00 05000 OPERATING ROOM	1, 012, 550		II.	•	665	1
52. 00 05200 DELIVERY ROOM & LABOR ROOM	183, 937				0	52.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	752, 659				2, 330	
54. 01 03630 ULTRA SOUND	23, 909				17	
56. 00 05600 RADI OI SOTOPE	90, 278				0	56.00
57. 00 05700 CT SCAN	20, 039			•	l	
58. 00 05800 MAGNETI C RESONANCE I MAGING (MRI)	13, 383				30	
59. 00 05900 CARDI AC CATHETERI ZATI ON 60. 00 06000 LABORATORY	27, 768				0	59. 00 60. 00
	252, 098				4, 211	
65. 00 06500 RESPI RATORY THERAPY 66. 00 06600 PHYSI CAL THERAPY	124, 768 219, 795					
67. 00 06700 OCCUPATI ONAL THERAPY	84, 900			,		
68. 00 06700 OCCUPATIONAL THERAPY	24, 370					
69. 00 06900 ELECTROCARDI OLOGY	229, 018					
· · · · · · · · · · · · · · · · · · ·				•	•	
70.00 07000 ELECTROENCEPHALOGRAPHY 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	79, 285 180, 118					1
72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS	81, 156					71.00
73. 00 07300 DRUGS CHARGED TO PATTENTS	553, 577			•	4, 930	
74. 00 07400 RENAL DIALYSIS	7. 999				625	
76. 00 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	104, 020				025	1
76. 01 03190 CHEMOTHERAPY	153, 606				0	76.00
76. 02 03330 ENDOSCOPY	89, 829				0	76. 01
76. 03 03950 WOUND CARE CENTER	73, 599				0	76. 02
OUTPATIENT SERVICE COST CENTERS	73, 399	14, 279, 071	0.00515	4 0	U	70.03
91. 00 09100 EMERGENCY	421, 178	62, 871, 417	0.00669	9 0	0	91.00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	421, 178				0	
OTHER REIMBURSABLE COST CENTERS		2,300,374	· 0.00000	0	<u> </u>	72.00
95. 00 09500 AMBULANCE SERVICES						95. 00
200.00 Total (lines 50 through 199)	4, 803, 839	466, 146, 563		4, 930, 391	62 480	200.00
200.00 10tal (111163 00 till bugil 199)	4,000,009	1 +00, 140, 503	'1	4, 730, 371	1 02, 409	1200.00

	Financial Systems ST. TONMENT OF INPATIENT/OUTPATIENT ANCILLARY SER	JOSEPH HOSPITAL			Peri od:	eu of Form CMS- Worksheet D	2552-10
	GH COSTS				From 07/01/2017	Part IV	
			Component	CCN: 15-T010	To 06/30/2018	Date/Time Pre 11/26/2018 12	pared:
			Title	: XVIII	Subprovi der -	PPS	. 03 piii
	Cost Center Description	Non Dhysician	Nursing School	Nurcina Scho	IRF ool Allied Health	Allied Health	
	cost center bescription		Post-Stepdown	Inui Si iig Scric	Post-Stepdown		
		Cost	Adjustments		Adj ustments		
		1.00	2A	2.00	3A	3. 00	
	ANCILLARY SERVICE COST CENTERS	1.00		2.00	- Ort	0.00	
50.00		0	0		0 0	0	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	o	0		o c	o o	52.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	o	0		o c	218, 444	54.00
54. 01	03630 ULTRA SOUND	o	0		o c	73, 190	1
56.00	05600 RADI OI SOTOPE	o	0		o c	172, 193	1
57.00	05700 CT SCAN	o	0		0 0	95, 322	57.00
58. 00	05800 MAGNETIC RESONANCE I MAGING (MRI)	o	0		o c	26, 140	1
59.00	05900 CARDI AC CATHETERI ZATI ON	o	0		0 0	ol o	59.00
60.00	06000 LABORATORY	o	0		o c	o o	60.00
65.00	06500 RESPIRATORY THERAPY	o	0		0 0	ol o	65.00
66.00	06600 PHYSI CAL THERAPY	o	0		0 0	ol o	66.00
67.00	06700 OCCUPATI ONAL THERAPY	o	0		0 0	ol o	67.00
68.00	06800 SPEECH PATHOLOGY	o	0		0 0	ol o	68. 00
69.00	06900 ELECTROCARDI OLOGY	o	0		0 0	ol o	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	ol	0		0 0	ol o	70.00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	o	0		0	o o	71.00
	07200 I MPL. DEV. CHARGED TO PATIENTS	o	0		o c	ol o	72.00
73. 00	07300 DRUGS CHARGED TO PATIENTS	o	0		o c	ol o	73. 00
74.00	I I	o	0		o c	ol o	74.00
		o	0		o	o o	
76. 01	03190 CHEMOTHERAPY	l	0		o	o o	
76. 02	03330 ENDOSCOPY	o	0		o d	ol o	76. 02
	03950 WOUND CARE CENTER	o	0		0	o o	
	OUTPATIENT SERVICE COST CENTERS			•	,		1
91.00	09100 EMERGENCY	0	C		0 (0	91.00

0

0

0

91.00 0

92.00 0

95.00

585, 289 200. 00

91. 00 | 09100 | EMERGENCY | 92. 00 | 09200 | 0BSERVATION | BEDS (NON-DISTINCT PART) | 0THER | REIMBURSABLE | COST | CENTERS | 09500 | AMBULANCE | SERVICES | 200. 00 | Total (Lines 50 through 199)

Real th Financial Systems ST. JOSEPH HOSPITAL & HEALTH (EMTER In Lieu of Form (DRS-2552-10 APPORTIONINNT) of INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS Component COI: 15-0010 Form (DRS-2552-10 APPORTIONINE) Component COI: 15-0010 Component COI: 15-0010 Form (DRS-2552-10 APPORTIONINE) Component COI: 15-0010 Form (DRS-2552-10 APPORTIONINE) Component COI: 15-0010 Form (DRS-2552-10 APPORTIONINE) Component COI: 15-0010 Component COI: 15-0010 Component COI: 15-0010 Color			IOCEDII HOCDI TAI	O LIEAL THE OFNI			C.E. OHC.	0550 40
THROUGH COSTS								2552-10
Component CCh: 15-T010 To			WICE OTHER TAS	I TOVI dei o	SIV. 13 0010		Part IV	
Cost Center Description	1111100011 0	0010		Component	CCN: 15-T010	To 06/30/2018		pared:
ANCILLARY SERVICE COST CENTERS A. 0.0 Cost (sum of col 1 through col. 2, 3 and col. 3, 4 and col. 2, 3 and col. 3, 4 and col. 2, 3 and col. 3, 4 and c				T' 11	\0.41 L L	6.1		:03 pm
All Other Medical Education Cost Medical Education Cost Sum of				litie	XVIII		PPS	
Medical Education Cost Sum of Col 1 Through col . Cost (Sum of Part I . Col . S + Col . S + Col . Part I . Col . S + Col .		Cost Center Description	All Other	Total Cost	Total		Ratio of Cost	
Education Cost		oost center bescription						
ANCILLARY SERVICE COST CENTERS								
ANCI LLARY SERVICE COST CENTERS			Eddodti oii oost					
A,00 5.00 6.00 7.00 8.00				.,			.,	
ANCILLARY SERVICE COST CENTERS			4.00	5. 00		7. 00	8. 00	
52. 00 05200 DELIVERY ROOM & LABOR ROOM 0 0 0 13, 471, 098 0.000000 52. 00 54. 00 05400 RADI OLOGY-DIAGNOSTIC 0 218, 444 218, 444 24, 490, 166 0.008920 54. 00 54. 00 05600 RADI OLOGY-DIAGNOSTIC 0 73, 190 73, 190 82, 042, 204 0.008921 54. 00 55. 00 05600 RADI OLOGY-DIAGNOSTIC 0 172, 193 172, 193 19, 302, 004 0.008921 55. 00 57. 00 05700 CT SCAN 0 95, 322 95, 322 10, 685, 097 0.008921 55. 00 58. 00 05800 MAGNETI C RESONANCE I MAGI NG (MRI) 0 26, 140 26, 140 2, 930, 175 0.008921 58. 00 59. 00 05900 CARDI AC CATHETERI ZATI ON 0 0 0 0 1, 787, 397 0.000000 59. 00 60. 00 6000 LABORATORY 0 0 0 0 68, 490, 956 0.000000 65. 00 65. 00 06500 RESPI RATORY THERAPY 0 0 0 0 12, 130, 031 0.000000 65. 00 66. 00 06600 OHYSI CAL THERAPY 0 0 0 0 13, 904, 695 0.000000 67. 00 68. 00 06600 OHYSI CAL THERAPY 0 0 0 0 14, 616, 280 0.000000 67. 00 69. 00 06900 ELECTROENCEPHALOGRAPHY 0 0 0 0 14, 616, 280 0.000000 67. 00 69. 00 06900 ELECTROENCEPHALOGRAPHY 0 0 0 0 14, 616, 280 0.000000 70. 00 71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENTS 0 0 0 0 14, 842, 764 0.000000 72. 00 72. 00 07200 IMPL DEV. CHARGED TO PATI ENTS 0 0 0 0 57, 308, 686 0.000000 72. 00 73. 00 07300 DRUGS CHARGED TO PATI ENTS 0 0 0 57, 308, 686 0.000000 76. 00 74. 00 07400 REMAL DIALYSIS 0 0 0 57, 308, 686 0.000000 76. 00 75. 01 03190 CHEMOTHERAPY 0 0 0 0 57, 308, 686 0.000000 76. 00 76. 01 03190 CHEMOTHERAPY 0 0 0 0 0 57, 308, 686 0.000000 76. 00 76. 01 03190 CHEMOTHERAPY 0 0 0 0 0 0 57, 308, 686 0.000000 76. 00 76. 01 03190 CHEMOTHERAPY 0 0 0 0 0 0 0 0 0	ANC	CILLARY SERVICE COST CENTERS			•	•		
54.00 05400 RADI OLOGY-DI AGNOSTI C 0 218, 444 218, 444 24, 490, 166 0.008920 54.00 54.01 03530 ULTRA SOUND 0 73, 190 73, 190 8, 204, 204 0.008921 54.00 55.00 05600 RADI OLSTOPE 0 172, 193 172, 193 19, 302, 004 0.008921 56.00 57.00 05700 CT SCAN 0 95, 322 95, 322 10, 685, 097 0.008921 57.00 58.00 05800 MAGNETI C RESONANCE I MAGING (MRI) 0 26, 140 29, 30, 175 0.008921 58.00 60.00 05900 CARDI AC CATHETERI ZATI ON 0 0 0 1, 787, 397 0.000000 58.00 66.00 06000 LABORATORY 0 0 0 68, 490, 956 0.000000 66.00 66.00 06500 RESPI RATORY THERAPY 0 0 0 12, 130, 031 0.000000 65.00 66.00 06600 PHYSI CAL THERAPY 0 0 0 13, 904, 695 0.000000 67.00 67.00 06700 OCCUPATI ONAL THERAPY 0 0 0 1, 589, 508 0	50.00 050	000 OPERATING ROOM	0	0		0 85, 536, 282	0.000000	50.00
54. 01 03630 ULTRA SOUND 0 73, 190 8, 204, 204 0. 008921 54. 01 56. 00 05600 RADI OI SOTOPE 0 172, 193 172, 193 172, 193 19, 302, 004 0. 008921 56. 00 05700 CT SCAN 0 95, 322 95, 322 10, 685, 097 0. 008921 57. 00 05700 CT SCAN 0 95, 322 95, 322 10, 685, 097 0. 008921 57. 00 05900 CARDI AC CATHETERI ZATI ON 0 26, 140 26, 140 2, 930, 175 0. 008921 58. 00 05900 CARDI AC CATHETERI ZATI ON 0 0 0 1, 787, 397 0. 000000 59. 00 0 0 68, 490, 956 0. 000000 60. 00 0 66. 00 0 60000 LABORATIORY 0 0 0 0 0 68, 490, 956 0. 000000 60. 00 0 0 0 0 0 0 0 0 0 0 0	52. 00 052	200 DELIVERY ROOM & LABOR ROOM	0	0		0 13, 471, 098	0.000000	52.00
56. 00 05600 RADI OI SOTOPE 0 172, 193 172, 193 19, 302, 004 0.008921 56. 00 57. 00 05700 CT SCAN 0 95, 322 95, 322 10, 685, 097 0.008921 57. 00 58. 00 05800 MAGNETI C RESONANCE I MAGI NG (MRI) 0 26, 140 2, 930, 175 0.008921 58. 00 05900 CARDI AC CATHETERI ZATI ON 0 0 0 1, 787, 397 0.000000 59. 00 0.0000 LABORATIORY 0 0 0 0 68, 490, 956 0.000000 65. 00 65. 00 65600 RESPI RATORY THERAPY 0 0 0 0 12, 130, 031 0.000000 65. 00 66. 00 6	54. 00 054	100 RADI OLOGY-DI AGNOSTI C	0	218, 444	218, 44	4 24, 490, 166	0. 008920	54.00
57. 00 05700 CT SCAN 0 95, 322 95, 322 10, 685, 097 0.008921 57. 00 58. 00 05800 MAGNETI C RESONANCE I MAGI NG (MRI) 0 26, 140 26, 140 2, 930, 175 0.008921 58. 00 59. 00 05900 CARDI AC CATHETERI ZATI ON 0 0 0 1, 787, 397 0.000000 59. 00 60. 00 06000 LABORATORY 0 0 0 0 68, 490, 956 0.000000 60. 00 65. 00 06500 RESPI RATORY THERAPY 0 0 0 0 12, 130, 031 0.000000 65. 00 66. 00 06600 PHYSI CAL THERAPY 0 0 0 0 13, 904, 695 0.000000 67. 00 67. 00 06700 OCCUPATI ONAL THERAPY 0 0 0 0 4, 589, 508 0.000000 67. 00 68. 00 06800 SPEECH PATHOLOGY 0 0 0 1, 014, 272 0.000000 67. 00 69. 00 06900 ELECTROCARDI OLOGY 0 0 0 14, 616, 280 0.000000 70. 00 70. 00 07000 ELECTROCARDI OLOGY 0 0 0 14, 616, 280 0.000000 70. 00 71. 00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS 0 0 0 12, 974, 948 0.000000 71. 00 72. 00 07300 DRUGS CHARGED TO PATI ENTS 0 0 0 12, 974, 948 0.000000 73. 00 74. 00 07300 DRUGS CHARGED TO PATI ENTS 0 0 0 12, 974, 948 0.000000 73. 00 75. 00 07300 RENAL DI ALYSI S 0 0 0 0 57, 308, 686 0.000000 73. 00 76. 01 03190 CHEMOTHERAPY 0 0 0 0 0 57, 308, 686 0.000000 76. 01 76. 02 03330 ENDOSCOPY 0 0 0 0 5, 364, 054 0.000000 76. 01 76. 01 03190 CHEMOTHERAPY 0 0 0 0 0 5, 364, 054 0.000000 76. 01 76. 02 03330 ENDOSCOPY 0 0 0 0 5, 364, 054 0.000000 76. 01 76. 02 07500 DRUGS CHARGED TO PATI ENTS 0 0 0 0 0 5, 364, 054 0.000000 76. 01 76. 01 03190 CHEMOTHERAPY 0 0 0 0 0 5, 364, 054 0.000000 76. 01 76. 02 07500 DRUGS CHARGED TO PATI ENTS 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	54. 01 036	530 ULTRA SOUND	0	73, 190	73, 19	0 8, 204, 204	0. 008921	54. 01
57. 00 05700 CT SCAN 0 95, 322 95, 322 10, 685, 097 0.008921 57. 00	56. 00 056	600 RADI OI SOTOPE	0	172, 193	172, 19	3 19, 302, 004	0. 008921	56.00
59.00 05900 CARDI AC CATHETERI ZATI ON 0 0 0 1, 787, 397 0.000000 59.00	57. 00 057	700 CT SCAN	0			2 10, 685, 097	0. 008921	57. 00
59.00 05900 CARDI AC CATHETERI ZATI ON 0 0 0 1, 787, 397 0.000000 59.00	58. 00 058	BOO MAGNETIC RESONANCE IMAGING (MRI)	0					58. 00
65. 00 06500 RESPIRATORY THERAPY 0 0 0 12, 130, 031 0.000000 65. 00 66. 00 06600 PHYSI CAL THERAPY 0 0 0 13, 904, 695 0.000000 66. 00 67. 00 06700 OCCUPATI ONAL THERAPY 0 0 0 0 4, 589, 508 0.000000 67. 00 0 4, 589, 508 0.000000 67. 00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0			0	0		0 1, 787, 397	0.000000	59. 00
65. 00 06500 RESPIRATORY THERAPY 0 0 0 0 12, 130, 031 0.000000 65. 00 66. 00 06600 PHYSI CAL THERAPY 0 0 0 0 13, 904, 695 0.000000 66. 00 0 0 13, 904, 695 0.000000 66. 00 0 0 13, 904, 695 0.000000 66. 00 0 0 0 0 0 0 0 0 0 0 0 0	60.00 060	000 LABORATORY	0	0				60.00
67. 00	65. 00 065	500 RESPIRATORY THERAPY	0	0				65. 00
67. 00	66. 00 066	500 PHYSI CAL THERAPY	0	0				66. 00
69. 00	67. 00 067	700 OCCUPATIONAL THERAPY	0	0		0 4, 589, 508	0.000000	67. 00
70. 00	68. 00 068	BOO SPEECH PATHOLOGY	0	0		0 1, 014, 272	0.000000	68. 00
71. 00	69. 00 069	POO ELECTROCARDI OLOGY	0	0		0 14, 616, 280	0.000000	69. 00
72. 00	70.00 070	000 ELECTROENCEPHALOGRAPHY	0	0		0 6, 744, 909	0.000000	70. 00
73. 00 07300 DRUGS CHARGED TO PATIENTS 0 0 0 57, 308, 686 0.000000 73. 00 74. 00 7	71. 00 071	100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		0 14, 842, 764	0. 000000	71. 00
74. 00	72. 00 072	200 IMPL. DEV. CHARGED TO PATIENTS	0	0		0 12, 974, 948	0.000000	72. 00
76. 00	73. 00 073	BOO DRUGS CHARGED TO PATIENTS	0	0		0 57, 308, 686	0.000000	73. 00
76. 01 03190 CHEMOTHERAPY 0 0 0 5, 021, 049 0. 000000 76. 01 76. 02 03330 ENDOSCOPY 0 0 0 3, 026, 209 0. 000000 76. 02 76. 03 0350 WOUND CARE CENTER 0 0 0 14, 279, 671 0. 000000 76. 03 OUTPATI ENT SERVI CE COST CENTERS 91. 00 09100 EMERGENCY 0 0 0 0 62, 871, 417 0. 000000 91. 00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART) 0 0 0 0 2, 308, 574 0. 000000 92. 00 OTHER REI MBURSABLE COST CENTERS 95. 00 09500 AMBULANCE SERVI CES	74. 00 074	100 RENAL DIALYSIS	0	0		0 252, 117	0.000000	74. 00
76. 02 03330 ENDOSCOPY 0 0 0 3, 026, 209 0. 000000 76. 02 76. 03 03950 WOUND CARE CENTER 0 0 0 14, 279, 671 0. 000000 76. 03 OUTPATI ENT SERVI CE COST CENTERS 91. 00 09100 EMERGENCY 0 0 0 62, 871, 417 0. 000000 91. 00 092.00 0BSERVATI ON BEDS (NON-DI STINCT PART) 0 0 0 0 2, 308, 574 0. 000000 92. 00 OTHER REI MBURSABLE COST CENTERS 95. 00 09500 AMBULANCE SERVI CES	76. 00 035	550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	0	0		0 5, 364, 054	0. 000000	76. 00
76. 03 03950 WOUND CARE CENTER 0 0 0 14, 279, 671 0.000000 76. 03 OUTPATIENT SERVICE COST CENTERS 91. 00 09100 EMERGENCY 0 0 0 62, 871, 417 0.000000 91. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 0 0 0 2, 308, 574 0.000000 92. 00 OTHER REIMBURSABLE COST CENTERS 95. 00 09500 AMBULANCE SERVICES 95. 00	76. 01 031	190 CHEMOTHERAPY	0	0		0 5, 021, 049	0.000000	76. 01
OUTPATIENT SERVICE COST CENTERS 91.00 09100 EMERGENCY 00 00 00 00 00 00 00	76. 02 033	330 ENDOSCOPY	0	0		0 3, 026, 209	0. 000000	76. 02
91. 00	76. 03 039	950 WOUND CARE CENTER	0	0		0 14, 279, 671	0. 000000	76. 03
92. 00 09200 0BSERVATI ON BEDS (NON-DISTINCT PART) 0 0 0 2,308,574 0.000000 92. 00 0THER REIMBURSABLE COST CENTERS 95. 00 09500 AMBULANCE SERVICES 95. 00	OUT	PATIENT SERVICE COST CENTERS						
OTHER REI MBURSABLE COST CENTERS 95. 00 09500 AMBULANCE SERVI CES 95. 00	91. 00 091	100 EMERGENCY	0	0				91. 00
95. 00 09500 AMBULANCE SERVI CES 95. 00	92. 00 092	200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0		0 2, 308, 574	0. 000000	92.00
200.00 Total (Lines 50 through 199) 0 585, 289 585, 289 466, 146, 563 200.00								95. 00
	200.00	Total (lines 50 through 199)	0	585, 289	585, 28	9 466, 146, 563		200. 00

Health Financial Systems ST. APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SER	JOSEPH HOSPITAL	& HEALTH CENT		In Lie	u of Form CMS-: Worksheet D	2552-10
THROUGH COSTS	RVICE UTHER PASS			From 07/01/2017 To 06/30/2018	Part IV	
		Title	XVIII	Subprovider - IRF	PPS	
Cost Center Description	Outpati ent	I npati ent	I npati ent	Outpati ent	Outpati ent	
	Ratio of Cost	Program	Program	Program	Program	
	to Charges	Charges	Pass-Through		Pass-Through	
	(col. 6 ÷ col.		Costs (col.	3	Costs (col. 9	
	7)		x col. 10)		x col. 12)	
	9. 00	10.00	11. 00	12.00	13. 00	
ANCI LLARY SERVICE COST CENTERS						
50. 00 05000 OPERATI NG ROOM	0. 000000	56, 155		0	0	50. 00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0. 000000	0		0	0	52. 00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 008920	75, 827	67		0	54.00
54.01 03630 ULTRA SOUND	0. 008921	5, 728	5	0	0	54. 01
56. 00 05600 RADI 0I SOTOPE	0. 008921	0		0	0	56. 00
57.00 05700 CT SCAN	0. 008921	27, 200			0	57. 00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0. 008921	6, 650	5	9 0	0	58. 00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0. 000000	0		0	0	59. 00
60. 00 06000 LABORATORY	0. 000000	1, 143, 957		0	0	60.00
65. 00 06500 RESPIRATORY THERAPY	0. 000000	399, 648		0	0	65. 00
66. 00 06600 PHYSI CAL THERAPY	0. 000000	1, 206, 028		0	0	66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	0. 000000	1, 035, 283		0	0	67. 00
68. 00 06800 SPEECH PATHOLOGY	0. 000000	163, 235		0	0	68. 00
69. 00 06900 ELECTROCARDI OLOGY	0. 000000	16, 652		0	0	69. 00
70. 00 07000 ELECTROENCEPHALOGRAPHY	0. 000000	3, 348		0	0	70. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 000000	246, 699		0	0	71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 000000	13, 920		0	0	72. 00
73. 00 07300 DRUGS CHARGED TO PATIENTS	0. 000000	510, 377		0	0	73. 00
74. 00 07400 RENAL DI ALYSI S	0. 000000	19, 684		0	0	74. 00
76. 00 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	0. 000000	0		0	0	76. 00
76. 01 03190 CHEMOTHERAPY	0. 000000	0		0	0	76. 01
76. 02 03330 ENDOSCOPY	0. 000000	0		0	0	76. 02
76. 03 03950 WOUND CARE CENTER	0. 000000	0		0 0	0	76. 03
OUTPATIENT SERVICE COST CENTERS						
91. 00 09100 EMERGENCY	0. 000000	0		0	0	91. 00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 000000	0		0 0	0	92.00
OTHER REIMBURSABLE COST CENTERS	1					
95. 00 09500 AMBULANCE SERVICES				_	_	95. 00
200.00 Total (lines 50 through 199)		4, 930, 391	1, 02	9 0	0	200. 00

Heal t	n Financial	Systems			ST. J	OSEPH HOSPITA	L & F	HEALTH CENT	ΓER	In Li€	eu of Form CMS-2	2552-10
APPOR	TI ONMENT OF	I NPATI ENT	ROUTINE SE	ERVI CE (OTHER PASS	S THROUGH COS	STS F	Provider C	CN: 15-0010	Peri od:	Worksheet D	
										From 07/01/2017		
										To 06/30/2018	Date/Time Pre	
											11/26/2018 12	:03 pm_
								Ti tl	e XIX	Hospi tal	Cost	
	Cost	Center Des	scription		N	ursing School	Nurs	ing School	Allied Heal	h Allied Health	All Other	
					F	Post-Stepdown			Post-Stepdo	n Cost	Medi cal	
						Adiustmonts			Adiustmont		Education Cost	

				From 07/01/2017 Fo 06/30/2018		
		Ti tl	e XIX	Hospi tal	Cost	. 03 piii
Cost Center Description	Nursing School			Allied Health	All Other	
·	Post-Stepdown	ŭ	Post-Stepdowr		Medi cal	
	Adjustments		Adjustments		Education Cost	
	1A	1.00	2A	2. 00	3. 00	
I NPATI ENT ROUTI NE SERVI CE COST CENTERS						
30. 00 03000 ADULTS & PEDIATRICS	0	0		0	0	
31.00 03100 INTENSIVE CARE UNIT	0	0		0	0	
41. 00 04100 SUBPROVI DER - I RF	0	0		0	0	
43. 00 04300 NURSERY	0	0		0	0	
200.00 Total (lines 30 through 199)	0	0		0		200. 00
Cost Center Description	Swi ng-Bed	Total Costs		Per Diem (col.	Inpati ent	
	Adjustment	(sum of cols.	Days	5 ÷ col. 6)	Program Days	
	Amount (see	1 through 3,				
		minus col. 4)				
	4. 00	5. 00	6. 00	7. 00	8. 00	
I NPATI ENT ROUTI NE SERVI CE COST CENTERS			1	.1	1	
30. 00 03000 ADULTS & PEDI ATRI CS	0	0	15, 77			
31. 00 03100 I NTENSI VE CARE UNI T		0	1, 81			31. 00
41. 00 04100 SUBPROVI DER - I RF	0	0	3, 54		1	41. 00
43. 00 04300 NURSERY		0	2, 16			43. 00
200.00 Total (lines 30 through 199)		0	23, 30	0	513	200. 00
Cost Center Description	Inpati ent					
	Program					
	Pass-Through					
	Cost (col. 7 x					
	col. 8) 9.00					
INPATIENT ROUTINE SERVICE COST CENTERS	9.00					
30. 00 03000 ADULTS & PEDIATRICS						30.00
31. 00 03100 NTENSI VE CARE UNIT	0					31.00
41. 00 04100 SUBPROVI DER -	0					41.00
43. 00 04300 NURSERY						41.00
200.00 Total (lines 30 through 199)	ı U					200. 00

| In Lieu of Form CMS-2552-10 | Peri od: | Worksheet D | From 07/01/2017 | Part IV | To 06/30/2018 | Date/Time Prepared: | THROUGH COSTS

					10 00/00/2010	11/26/2018 12	
			Ti tl	e XIX	Hospi tal	Cost	
	Cost Center Description	Non Physician I	Nursing School	Nursing Schoo	Allied Health	Allied Health	
			Post-Stepdown		Post-Stepdown		
		Cost	Adjustments		Adjustments		
		1.00	2A	2. 00	3A	3. 00	
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATI NG ROOM	0	0		0	0	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0		0	0	52.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0	0		0	218, 444	54. 00
54. 01	03630 ULTRA SOUND	0	0		0	73, 190	1
56. 00	05600 RADI 0I SOTOPE	0	0		0	172, 193	1
57.00	05700 CT SCAN	0	0		0	95, 322	57. 00
58. 00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0		0	26, 140	58. 00
59. 00	05900 CARDI AC CATHETERI ZATI ON	0	0		0	0	59. 00
60.00	06000 LABORATORY	0	0		0	0	60.00
65. 00	06500 RESPI RATORY THERAPY	0	0		0	0	65.00
66.00	06600 PHYSI CAL THERAPY	0	0		0	0	66. 00
67.00	06700 OCCUPATI ONAL THERAPY	0	0		0	0	67. 00
68.00	06800 SPEECH PATHOLOGY	0	0		0	0	68. 00
69. 00	06900 ELECTROCARDI OLOGY	0	0		0	0	69. 00
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0		0	0	70. 00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		0	0	71. 00
72.00	07200 I MPL. DEV. CHARGED TO PATIENTS	0	0		0	0	72. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0		0	0	73. 00
74.00	07400 RENAL DIALYSIS	0	0		0	0	74. 00
76.00	03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	0	0		0	0	76. 00
76. 01	03190 CHEMOTHERAPY	0	0		0	0	76. 01
76. 02	03330 ENDOSCOPY	0	0		0	0	76. 02
76. 03	03950 WOUND CARE CENTER	0	0		0	0	76. 03
	OUTPATIENT SERVICE COST CENTERS						ĺ
91.00	09100 EMERGENCY	0	C		0 0	0	91. 00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0			0	0	92.00
	OTHER REIMBURSABLE COST CENTERS						
95.00	09500 AMBULANCE SERVI CES						95. 00
200.00	Total (lines 50 through 199)	0	0		0	585, 289	200. 00
						,	

| In Lieu of Form CMS-2552-10 | Peri od: | Worksheet D | From 07/01/2017 | Part IV | To 06/30/2018 | Date/Time Prepared: | THROUGH COSTS

			'	0 00/00/2010	11/26/2018 12	
		Ti tl	e XIX	Hospi tal	Cost	
Cost Center Description	All Other	Total Cost	Total	Total Charges	Ratio of Cost	
	Medi cal	(sum of col 1	Outpati ent	(from Wkst. C,	to Charges	
	Education Cost	through col.	Cost (sum of	Part I, col.	(col. 5 ÷ col.	
		4)	col. 2, 3 and	8)	7)	
			4)			
	4. 00	5. 00	6. 00	7. 00	8. 00	
ANCI LLARY SERVI CE COST CENTERS						
50.00 05000 OPERATING ROOM	0	0	0	85, 536, 282	0.000000	
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0	0	13, 471, 098		
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	218, 444	218, 444	24, 490, 166	0. 008920	54.00
54.01 03630 ULTRA SOUND	0	73, 190	73, 190	8, 204, 204		54. 01
56. 00 05600 RADI 0I SOTOPE	0	172, 193	172, 193	19, 302, 004	0. 008921	56. 00
57. 00 05700 CT SCAN	0	95, 322	95, 322	10, 685, 097	0. 008921	57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	26, 140	26, 140	2, 930, 175	0. 008921	58. 00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0	0	C	1, 787, 397	0.000000	59. 00
60. 00 06000 LABORATORY	0	0	C	68, 490, 956	0.000000	60.00
65. 00 06500 RESPIRATORY THERAPY	0	0	C	12, 130, 031	0.000000	65. 00
66. 00 06600 PHYSI CAL THERAPY	0	0	C	13, 904, 695	0.000000	66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	0	0	C	4, 589, 508	0.000000	67. 00
68.00 06800 SPEECH PATHOLOGY	0	0	C	1, 014, 272	0.000000	68. 00
69. 00 06900 ELECTROCARDI OLOGY	0	0	l c	14, 616, 280	0.000000	69. 00
70. 00 07000 ELECTROENCEPHALOGRAPHY	0	0	l c	6, 744, 909	0.000000	70. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	l c	14, 842, 764	0.000000	71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	l c	12, 974, 948	0.000000	72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0	l c	57, 308, 686		73. 00
74.00 07400 RENAL DIALYSIS	0	0		252, 117	0.000000	74.00
76. 00 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	0	0	l c	5, 364, 054	0. 000000	76. 00
76. 01 03190 CHEMOTHERAPY	0	0	l c	5, 021, 049	0. 000000	76. 01
76. 02 03330 ENDOSCOPY	0	0	l c	3, 026, 209		76. 02
76. 03 03950 WOUND CARE CENTER	0	0	l c	14, 279, 671	0. 000000	76. 03
OUTPATIENT SERVICE COST CENTERS			<u>'</u>			
91. 00 09100 EMERGENCY	0	0	C	62, 871, 417	0.000000	91.00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0		1		1
OTHER REIMBURSABLE COST CENTERS			·	,		1
95. 00 09500 AMBULANCE SERVICES						95. 00
200.00 Total (lines 50 through 199)	0	585, 289	585, 289	466, 146, 563		200. 00
	'				•	•

Health Financial Systems	ST. JOSEPH HOSPITAL &	HEALTH CENTER	In Lie	u of Form CMS-2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT	F ANCILLARY SERVICE OTHER PASS	Provider CCN: 15-0010	Peri od:	Worksheet D

From 07/01/2017 Part IV
To 06/30/2018 Date/Time Prepared: THROUGH COSTS 11/26/2018 12:03 pm Title XIX Hospi tal Cost Outpati ent I npati ent Outpati ent Cost Center Description Inpatient Outpati ent Ratio of Cost Program Program Program Program to Charges Pass-Through Pass-Through Charges Charges Costs (col. (col. 6 ÷ col Costs (col. x col . 12) 13.00 7) x col. 10) 11. 00 9.00 10.00 12.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 0.000000 2, 889, 395 0 50.00 0 05200 DELIVERY ROOM & LABOR ROOM 52.00 0.000000 4, 924, 588 0 0 52.00 05400 RADI OLOGY-DI AGNOSTI C 0.008920 237, 617 2, 120 54.00 54.00 0 03630 ULTRA SOUND 0.008921 117, 102 54.01 54.01 1.045 0 0. 008921 05600 RADI OI SOTOPE 73, 480 56.00 656 0 56.00 57.00 05700 CT SCAN 0.008921 221, 635 1,977 0 57.00 58.00 05800 MAGNETIC RESONANCE I MAGING (MRI) 0.008921 51, 203 457 0 58.00 05900 CARDIAC CATHETERIZATION 59.00 0.000000 0 59.00 78, 421 O 06000 LABORATORY 0.000000 3, 794, 777 60.00 60.00 0 0 65.00 06500 RESPIRATORY THERAPY 0.000000 849, 750 0 65.00 06600 PHYSI CAL THERAPY 0.000000 66.00 203, 037 0 0 66.00 0 06700 OCCUPATIONAL THERAPY 0.000000 72, 574 67.00 67 00 0 68.00 06800 SPEECH PATHOLOGY 0.000000 18, 092 0 68.00 06900 ELECTROCARDI OLOGY 0.000000 183, 634 0 69.00 69.00 0 0 70.00 07000 ELECTROENCEPHALOGRAPHY 0.000000 70.00 16, 947 0 0 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 71.00 0.000000 547, 518 0 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0.000000 694, 583 0 0 72.00 07300 DRUGS CHARGED TO PATIENTS 1, 702, 515 0 73.00 0.000000 0 73.00 07400 RENAL DIALYSIS 74 00 0.000000 0 Ω 74 00 15, 548 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES 76.00 0.000000 3, 111 0 76.00 76. 01 03190 CHEMOTHERAPY 0.000000 14, 917 0 76.01 03330 ENDOSCOPY 0 0 76. 02 0.000000 31, 720 0 76.02 03950 WOUND CARE CENTER 0.000000 60,002 0 0 76.03 76.03 0 OUTPAȚI ENT SERVI CE COST CENTERS 09100 EMERGENCY 91.00 0.000000 1, 231, 478 0 0 0 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 0.000000 0 92.00 92.00 0 0 OTHER REIMBURSABLE COST CENTERS 95.00 09500 AMBULANCE SERVICES 95.00 200.00 Total (lines 50 through 199) 18, 033, 644 6, 255 0 0 200. 00

Health Financial Systems	ST. JOSEPH HOSPITAL &	HEALTH CENTER	In Lieu	u of Form CMS-2552-10
ADDODEL OF MEDICAL	OTHER HEALTH OFFILE OF AND MARCHIE COOT	D 1.1 00N 4E 0040	6	W 1 1 1 D

Health Fina	ncial Systems ST.	JOSEPH HOSPITAL	L & HEALTH CEN	ΓER	In Lie	u of Form CMS-	2552-10
APPORTI ONME	ENT OF MEDICAL, OTHER HEALTH SERVICES AND	VACCINE COST	Provi der C		Peri od:	Worksheet D	
					From 07/01/2017	Part V	
					To 06/30/2018		pared:
			Ti +I	e XIX	Hospi tal	11/26/2018 12 Cost	: U3 piii
			11 (1	Charges	1103pi tai	Costs	
	Cost Center Description	Cost to Charge	PPS Reimbursed		Cost	PPS Services	
	cost center bescription	Ratio From	Services (see	Rei mbursed	Rei mbursed	(see inst.)	
		Worksheet C,	inst.)	Servi ces	Services Not	(See Hist.)	
		Part I, col. 9	,	Subject To	Subject To		
		1 41 1 7 , 601. 7		Ded. & Coins.	Ded. & Coins.		
				(see inst.)	(see inst.)		
		1.00	2.00	3.00	4. 00	5. 00	
ANCL	LLARY SERVICE COST CENTERS	1.00	2.00	3.00	4.00	3.00	
	O OPERATING ROOM	0. 145457	0	5, 960, 56	5 0	0	50.00
	O DELIVERY ROOM & LABOR ROOM	0. 248956		1		Ö	52.00
	O RADI OLOGY-DI AGNOSTI C	0. 223063		1	9	0	
	O ULTRA SOUND	0. 090323				0	1
	O RADI OI SOTOPE	0. 106369	1	1		0	
	O CT SCAN	0. 100304		.,,	' "	0	57. 00
		0. 079194		1, 276, 93		0	
1	O MAGNETIC RESONANCE I MAGING (MRI)			2,,,20		_	58. 00
	O CARDI AC CATHETERI ZATI ON	0. 163360				0	
	O LABORATORY	0. 116029		-,,		0	
	O RESPI RATORY THERAPY	0. 204461	0			0	65.00
1	O PHYSI CAL THERAPY	0. 334459	•	.,, .		0	66. 00
	O OCCUPATI ONAL THERAPY	0. 373557	0	,		0	67. 00
	O SPEECH PATHOLOGY	0. 439925				0	
	0 ELECTROCARDI OLOGY	0. 112278		, , , , ,		0	07.00
	O ELECTROENCEPHALOGRAPHY	0. 167778	ł .	1,		0	70. 00
	O MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 171343		383, 89	5 0	0	71. 00
	O IMPL. DEV. CHARGED TO PATIENTS	0. 301548	0	487, 01	0	0	72. 00
	O DRUGS CHARGED TO PATIENTS	0. 432219	0	5, 745, 34	4 0	0	73. 00
	O RENAL DIALYSIS	1. 514658	0	1	0	0	74. 00
76. 00 0355	O PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	0. 444811	0	1, 654, 83	2 0	0	76. 00
76. 01 0319	O CHEMOTHERAPY	1. 382876	0	548, 81	9 0	0	76. 01
76. 02 0333	O ENDOSCOPY	0. 145136	0	258, 76	7 0	0	76. 02
76. 03 0395	O WOUND CARE CENTER	0. 097611	0	1, 386, 40	2 0	0	76. 03
OUTP	ATIENT SERVICE COST CENTERS						
91. 00 0910	O EMERGENCY	0. 083279	О	14, 886, 73	1 0	0	91.00
92. 00 0920	O OBSERVATION BEDS (NON-DISTINCT PART)	0. 418340		439, 78	6 0	0	92.00
	R REIMBURSABLE COST CENTERS	<u>'</u>	<u>'</u>	· · ·			
95. 00 0950	O AMBULANCE SERVICES	0. 228046	О	1, 796, 95	0		95. 00
200.00	Subtotal (see instructions)		l o			0	200. 00
201.00	Less PBP Clinic Lab. Services-Program				0 0		201. 00
	Only Charges						
202.00	Net Charges (line 200 - line 201)		i c	52, 678, 10	7 0	0	202. 00
		•	•			•	

					10 06/30/2018	11/26/2018 12	pared: :03 pm
			Ti tl	e XIX	Hospi tal	Cost	
	·	Cos	ts				
	Cost Center Description	Cost	Cost				
		Rei mbursed	Rei mbursed				
		Servi ces	Services Not				
		Subject To	Subject To				
			Ded. & Coins.				
		(see inst.)	(see inst.)				
		6.00	7. 00				
	ANCILLARY SERVICE COST CENTERS						
50. 00	05000 OPERATING ROOM	867, 006	0				50.00
52. 00	05200 DELIVERY ROOM & LABOR ROOM	159, 214	0				52. 00
54. 00	05400 RADI OLOGY-DI AGNOSTI C	586, 174	0				54.00
54. 01	03630 ULTRA SOUND	70, 012	0				54. 01
56.00	05600 RADI OI SOTOPE	174, 906	0				56. 00
57.00	05700 CT SCAN	101, 126	0				57. 00
58. 00	05800 MAGNETIC RESONANCE I MAGING (MRI)	60, 173	0				58. 00
59. 00	05900 CARDI AC CATHETERI ZATI ON	18, 739	0				59. 00
60.00	06000 LABORATORY	938, 383	0				60.00
65. 00	06500 RESPI RATORY THERAPY	110, 894	0				65. 00
66. 00	06600 PHYSI CAL THERAPY	410, 563	0				66. 00
67. 00	06700 OCCUPATI ONAL THERAPY	77, 297	0				67. 00
68. 00	06800 SPEECH PATHOLOGY	23, 869	0				68. 00
69. 00	06900 ELECTROCARDI OLOGY	78, 718	0				69. 00
70. 00	07000 ELECTROENCEPHALOGRAPHY	156, 302	0				70. 00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	65, 778	0				71. 00
72. 00	07200 I MPL. DEV. CHARGED TO PATIENTS	146, 857	0				72. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	2, 483, 247	0				73. 00
74.00	07400 RENAL DIALYSIS	0	0				74. 00
76.00	03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	736, 087	0				76. 00
76. 01	03190 CHEMOTHERAPY	758, 949	0				76. 01
76. 02	03330 ENDOSCOPY	37, 556	0				76. 02
76. 03	03950 WOUND CARE CENTER	135, 328	0				76. 03
	OUTPATIENT SERVICE COST CENTERS						
91. 00	09100 EMERGENCY	1, 239, 752	0				91. 00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	183, 980	0				92.00
	OTHER REIMBURSABLE COST CENTERS						
95. 00	09500 AMBULANCE SERVI CES	409, 787					95. 00
200.00		10, 030, 697	0				200. 00
201.00		0					201. 00
	Only Charges						
202.00	Net Charges (line 200 - line 201)	10, 030, 697	0				202. 00

Health Financial Systems	ST. JOSEPH HOSPITAL &	HEALTH CENTER	In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der CCN: 15-0010	Peri od: From 07/01/2017	Worksheet D-1	
			To 06/30/2018	Date/Time Pre 11/26/2018 12	pared: :03 pm_
		Title XVIII	Hospi tal	PPS	
Cost Center Description					
				1. 00	
PART I - ALL PROVIDER COMPONENTS					
I NPATI ENT DAYS					
1.00 Inpatient days (including private room	m days and swing-bed days	s, excluding newborn)		15, 779	1. 00

	Ittle XVIII Hospital	PPS	
	Cost Center Description	1. 00	
	PART I - ALL PROVIDER COMPONENTS		
	I NPATI ENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	15, 779	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	15, 779	
3. 00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.	0	3. 00
4.00	Semi-private room days (excluding swing-bed and observation bed days)	14, 748	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost	0	5. 00
	reporting period		,
6. 00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	6. 00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost	0	7. 00
	reporting period	-	
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost	0	8. 00
0.00	reporting period (if calendar year, enter 0 on this line)	F F04	
9. 00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)	5, 581	9. 00
10. 00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days)	0	10.00
	through December 31 of the cost reporting period (see instructions)		
11. 00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after	0	11. 00
12. 00	December 31 of the cost reporting period (if calendar year, enter 0 on this line) Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days)	0	12. 00
	through December 31 of the cost reporting period	١	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days)	0	13. 00
14. 00	after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	14 00
15. 00	Medically necessary private room days applicable to the Program (excluding swing-bed days) Total nursery days (title V or XIX only)	0	14. 00 15. 00
16. 00	Nursery days (title V or XIX only)	0	16. 00
	SWING BED ADJUSTMENT		
17. 00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost	0. 00	17. 00
18. 00	reporting period Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost	0. 00	18. 00
10.00	report in giperiod	0.00	10.00
19. 00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	0.00	19. 00
20. 00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost	0.00	20. 00
21. 00	reporting period Total general inpatient routine service cost (see instructions)	14, 780, 623	21. 00
22. 00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line	14, 700, 023	22. 00
	5 x line 17)		
23. 00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)	0	23. 00
24. 00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line	0	24. 00
	7 x line 19)		
25. 00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)	0	25. 00
26. 00	Total swing-bed cost (see instructions)	0	26. 00
27. 00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	14, 780, 623	27. 00
20.00	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		1 20 00
28. 00 29. 00	General inpatient routine service charges (excluding swing-bed and observation bed charges) Private room charges (excluding swing-bed charges)	0	28. 00 29. 00
30. 00	Semi -pri vate room charges (excluding swing-bed charges)	0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0. 000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)	0.00	
33. 00 34. 00	Average semi-private room per diem charge (line 30 ÷ line 4) Average per diem private room charge differential (line 32 minus line 33)(see instructions)	0. 00 0. 00	
35. 00	Average per diem private room cost differential (line 34 x line 31)	0.00	
36. 00	Private room cost differential adjustment (line 3 x line 35)	0	36. 00
37. 00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line	14, 780, 623	37. 00
	27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY		ł
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS		
38. 00	Adjusted general inpatient routine service cost per diem (see instructions)	936. 73	38. 00
39. 00	Program general inpatient routine service cost (line 9 x line 38)	5, 227, 890	
	Medically necessary private room cost applicable to the Program (line 14 x line 35) Total Program general inpatient routine service cost (line 39 + line 40)	0 5, 227, 890	40.00
4 I. UU	protor program goneral impatremt routine service cost (IIIIC 37 + IIIIC 40)	J. ZZ1. 090'	ı 🛨 ı. UU

Heal th	h Financial Systems ST. JOSEPH HOSPITAL & HEALTH CENTER	In Lie	u of Form CMS-2	2552-10
COMPUT	TATION OF INPATIENT OPERATING COST Provider CCN: 15-0010 Peri	od: 07/01/2017	Worksheet D-1	
	То	06/30/2018	Date/Time Prep 11/26/2018 12:	
		Hospi tal	PPS	. 00 рііі
	Cost Center Description Total Total Average Per Pr Inpati ent Cost Inpati ent Days Di em (col. 1 ÷	rogram Days	Program Cost (col. 3 x col.	
	col. 2)		4)	
42 00	1.00 2.00 3.00 NURSERY (title V & XIX only) 0 0 0.00	4. 00	5. 00	42. 00
	Intensive Care Type Inpatient Hospital Units	-		
43. 00 44. 00		1, 318	2, 367, 589	43. 00 44. 00
45. 00				45. 00
46.00				46.00
47.00	OTHER SPECIAL CARE (SPECIFY) Cost Center Description			47. 00
40.00	40 00 Program innotions and Hamy complex cost (What D.2 col. 2 Line 200)			40.00
48. 00 49. 00	00 Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200) 00 Total Program inpatient costs (sum of lines 41 through 48)(see instructions)			48. 00 49. 00
	PASS THROUGH COST ADJUSTMENTS			F0 00
50. 00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)			50. 00
51. 00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)			51. 00
52. 00				52. 00
53. 00				53. 00
	medical education costs (line 49 minus line 52) TARGET AMOUNT AND LIMIT COMPUTATION			
	Program discharges			54. 00
55. 00 56. 00	Target amount per discharge Target amount (line 54 x line 55)			55. 00 56. 00
57. 00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)			57. 00
58. 00 59. 00				58. 00 59. 00
37.00	market basket			
60. 00 61. 00				60. 00 61. 00
01.00	which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target			01.00
62. 00	amount (line 56), otherwise enter zero (see instructions) 2.00 Relief payment (see instructions)			62. 00
63. 00	00 Allowable Inpatient cost plus incentive payment (see instructions)			63. 00
64. 00	PROGRAM INPATIENT ROUTINE SWING BED COST Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See			64. 00
	instructions)(title XVIII only)			
65. 00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)			65. 00
66. 00				66. 00
67. 00	CAH (see instructions) Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period			67. 00
68. 00	(line 12 x line 19) 0 Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period			68. 00
	(line 13 x line 20)			
69. 00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68) PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY			69. 00
70. 00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)			70. 00
71. 00 72. 00				71. 00 72. 00
73. 00				73. 00
74. 00 75. 00		II column		74. 00 75. 00
73.00	26, line 45)	ii, cordiiii		73.00
76. 00 77. 00				76. 00 77. 00
78. 00	Inpatient routine service cost (line 74 minus line 77)			78. 00
79. 00 80. 00	Aggregate charges to beneficiaries for excess costs (from provider records) Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)			79.00
81.00	Inpatient routine service cost per diem limitation			80. 00 81. 00
82. 00	Inpatient routine service cost limitation (line 9 x line 81)			82. 00
83. 00 84. 00	Reasonable inpatient routine service costs (see instructions) Program inpatient ancillary services (see instructions)			83. 00 84. 00
85. 00	Utilization review - physician compensation (see instructions)			85. 00
86. 00	Total Program inpatient operating costs (sum of lines 83 through 85) PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST			86. 00
87. 00	Total observation bed days (see instructions)		1, 031	87. 00
88. 00 89. 00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2) Observation bed cost (line 87 x line 88) (see instructions)		936. 73 965, 769	
57.00		l	700, 707	07.00

Health Financial Systems ST	. JOSEPH HOSPITA	L & HEALTH CENT	ER	In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der CO		Period: From 07/01/2017	Worksheet D-1	
				To 06/30/2018	Date/Time Pre 11/26/2018 12	
		Title	XVIII	Hospi tal	PPS	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observation	
		(from line 21)	column 2	Observati on	Bed Pass	
				Bed Cost (from	Through Cost	
				line 89)	(col. 3 x col.	
					4) (see	
					instructions)	
	1.00	2.00	3.00	4. 00	5. 00	
COMPUTATION OF OBSERVATION BED PASS THROUGH	I COST					
90.00 Capital -related cost	917, 542	14, 780, 623	0. 06207	7 965, 769	59, 952	90. 00
91.00 Nursing School cost	0	14, 780, 623	0.00000	965, 769	0	91. 00
92.00 Allied health cost	0	14, 780, 623	0.00000	965, 769	0	92. 00
93.00 All other Medical Education	0	14, 780, 623	0. 00000	965, 769	0	93. 00

Health Financial Systems	ST. JOSEPH HOSPITAL &	HEALTH CENTER	In Lie	u of Form CMS-2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 15-0010		Worksheet D-1
		Component CCN: 15-T010	From 07/01/2017 To 06/30/2018	
		Title XVIII	Subprovi der -	PPS

		Title XVIII	Subprovi der - I RF	PPS	
	Cost Center Description	·	-	1. 00	
	PART I - ALL PROVIDER COMPONENTS			1.00	
	I NPATI ENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days			3, 547	1.00
2. 00 3. 00	Inpatient days (including private room days, excluding swing- Private room days (excluding swing-bed and observation bed da	<i>3</i> ,	ivata room dave	3, 547 0	2. 00 3. 00
3.00	do not complete this line.	ys). IT you have only pr	i vate i oom days,	U	3.00
4.00	Semi-private room days (excluding swing-bed and observation be	ed days)		3, 547	4. 00
5.00	Total swing-bed SNF type inpatient days (including private ro	om days) through Decembe	r 31 of the cost	0	5. 00
/ 00	reporting period		21 -6 +1+	0	/ 00
6. 00	Total swing-bed SNF type inpatient days (including private round reporting period (if calendar year, enter 0 on this line)	om days) after becember	31 of the cost	0	6. 00
7. 00	Total swing-bed NF type inpatient days (including private room	m days) through December	31 of the cost	0	7. 00
	reporting period	3 ,			
8. 00	Total swing-bed NF type inpatient days (including private room	m days) after December 3	1 of the cost	0	8. 00
9. 00	reporting period (if calendar year, enter 0 on this line) Total inpatient days including private room days applicable to	o the Program (eycluding	swing_hed and	2, 475	9. 00
7. 00	newborn days)	o the rrogram (exertaining	Swifing bed dild	2, 170	7. 00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII o		oom days)	0	10. 00
11 00	through December 31 of the cost reporting period (see instructions had SNE type inputions days applicable to title VVIII of		sem dovo) setter	0	11 00
11. 00	Swing-bed SNF type inpatient days applicable to title XVIII on December 31 of the cost reporting period (if calendar year, en	nter 0 on this line)	dom days) arter	U	11. 00
12.00	Swing-bed NF type inpatient days applicable to titles V or XII		e room days)	0	12. 00
	through December 31 of the cost reporting period				
13. 00	Swing-bed NF type inpatient days applicable to titles V or XI	3 \ 3 \	, ,	0	13. 00
14. 00	after December 31 of the cost reporting period (if calendar you Medically necessary private room days applicable to the Progra			0	14. 00
15. 00	Total nursery days (title V or XIX only)	am (exertaining swring bea	days)	0	15. 00
16.00	Nursery days (title V or XIX only)			0	16. 00
47.00	SWING BED ADJUSTMENT		6.11	0.00	47.00
17. 00	Medicare rate for swing-bed SNF services applicable to service reporting period	es through December 31 o	T the cost	0.00	17. 00
18. 00	Medicare rate for swing-bed SNF services applicable to service	es after December 31 of	the cost	0.00	18. 00
	reporting period				
19. 00	Medicald rate for swing-bed NF services applicable to services reporting period	s through December 31 of	the cost	0. 00	19. 00
20. 00	Medicald rate for swing-bed NF services applicable to services	s after December 31 of t	he cost	0.00	20. 00
	reporting period				
21. 00	Total general inpatient routine service cost (see instructions			3, 002, 694	21. 00
22. 00	Swing-bed cost applicable to SNF type services through December 5×1 ine 17)	er 31 of the cost report	ing period (iine	0	22. 00
23. 00	Swing-bed cost applicable to SNF type services after December	31 of the cost reportin	g period (line 6	0	23. 00
	x line 18)			_	
24. 00	Swing-bed cost applicable to NF type services through December 7×1 ine 19)	r 31 of the cost reporti	ng perioa (line	0	24. 00
25. 00	Swing-bed cost applicable to NF type services after December :	31 of the cost reporting	period (line 8	0	25. 00
	x line 20)				
26. 00 27. 00	Total swing-bed cost (see instructions) General inpatient routine service cost net of swing-bed cost	(Lino 21 minus Lino 26)		0 3, 002, 694	26. 00 27. 00
27.00	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT	(Title 21 millus Title 20)	l	3, 002, 094	27.00
28. 00	General inpatient routine service charges (excluding swing-be	d and observation bed ch	arges)	0	28. 00
29. 00	Private room charges (excluding swing-bed charges)			0	29. 00
30.00	Semi-private room charges (excluding swing-bed charges) General inpatient routine service cost/charge ratio (line 27	. line 20)		0. 000000	30. 00 31. 00
31. 00 32. 00	Average private room per diem charge (line 29 ÷ line 3)	- ITTle 20)		0.00000	
33. 00	Average semi-private room per diem charge (line 30 ÷ line 4)			0.00	33. 00
34. 00	Average per diem private room charge differential (line 32 mi		tions)	0.00	
35. 00	Average per diem private room cost differential (line 34 x line 35)	ne 31)		0.00	35. 00
36. 00 37. 00	Private room cost differential adjustment (line 3 x line 35) General inpatient routine service cost net of swing-bed cost	and private room cost di	fferential (line	0 3, 002, 694	36. 00 37. 00
37.00	27 minus line 36)				57.00
	PART II - HOSPITAL AND SUBPROVIDERS ONLY				
20 00	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJU			047.54	20 00
38. 00 39. 00	Adjusted general inpatient routine service cost per diem (see Program general inpatient routine service cost (line 9 x line			846. 54 2, 095, 187	38. 00 39. 00
40. 00	Medically necessary private room cost applicable to the Progra			2,073,107	40. 00
41. 00	Total Program general inpatient routine service cost (line 39			2, 095, 187	41. 00

	Financial Systems ST. ATION OF INPATIENT OPERATING COST	JOSEPH HOSPITAL		TER CN: 15-0010	Peri od:	eu of Form CMS-2 Worksheet D-1	
			Component	CCN: 15-T010	From 07/01/2017 To 06/30/2018	Date/Time Pre	
			Title	e XVIII	Subprovi der -	11/26/2018 12 PPS	:03 pm
	Cost Center Description	Total	Total	Average Per	IRF Program Days	Program Cost	
	·	Inpatient Cost	npatient Days	Diem (col. 1 col. 2)	÷	(col. 3 x col. 4)	
		1.00	2.00	3.00	4. 00	5. 00	
42. 00	NURSERY (title V & XIX only) Intensive Care Type Inpatient Hospital Units	0	(0.	00 0) 0	42.00
43. 00	INTENSIVE CARE UNIT	0	C	0.	00 0	0	
44. 00 45. 00	CORONARY CARE UNIT BURN INTENSIVE CARE UNIT						44. 00 45. 00
46.00	SURGICAL INTENSIVE CARE UNIT						46.00
47.00	OST Center Description						47. 00
48. 00	Program inpatient ancillary service cost (Wk	st D-3 col 3	line 200)			1. 00 1, 404, 759	48. 00
	Total Program inpatient costs (sum of lines			ons)		3, 499, 946	1
50. 00	PASS THROUGH COST ADJUSTMENTS Pass through costs applicable to Program inp.	atient routine s	ervices (from	n Wkst. D. su	n of Parts I and	163, 672	50.00
F1 00							
51. 00	Pass through costs applicable to Program inpand IV)	attent ancitrary	services (fr	OM WKSt. D,	sum of Parts II	63, 518	51.00
52. 00 53. 00	Total Program excludable cost (sum of lines Total Program inpatient operating cost exclu		ated non-nh	sician anast	netist and	227, 190 3, 272, 756	1
33.00	medical education costs (line 49 minus line		ated, non-pny	731 Clair allesti	leti St, and	3, 272, 730	33.00
54. 00	TARGET AMOUNT AND LIMIT COMPUTATION Program discharges					0] 54. 00
55.00	Target amount per discharge					0.00	1
56. 00 57. 00	Target amount (line 54 x line 55) Difference between adjusted inpatient operat	ing cost and tar	get amount (I	ine 56 minus	line 53)	0	
58. 00 59. 00	Bonus payment (see instructions) Lesser of lines 53/54 or 55 from the cost re	porting period e	ndina 1006 i	indated and co	omnounded by the	0.00	
	market basket			•			
60. 00 61. 00	Lesser of lines 53/54 or 55 from prior year of line 53/54 is less than the lower of line					0.00	1
	which operating costs (line 53) are less tha	n expected costs					
62. 00	amount (line 56), otherwise enter zero (see Relief payment (see instructions)	instructions)				0	62. 00
63. 00	Allowable Inpatient cost plus incentive paym PROGRAM INPATIENT ROUTINE SWING BED COST	ent (see instruc	tions)			0	63.00
64. 00	Medicare swing-bed SNF inpatient routine cos	ts through Decem	ber 31 of the	cost report	ng period (See	0	64. 00
65. 00	<pre>instructions)(title XVIII only) Medicare swing-bed SNF inpatient routine cos</pre>	ts after Decembe	r 31 of the d	cost reportin	g period (See	0	65. 00
66. 00	instructions)(title XVIII only) Total Medicare swing-bed SNF inpatient routi	ne costs (line 6	4 nlus line 6	5)(title XVI	II only) For	0	66. 00
	CAH (see instructions)	·	•	, ,	3,		
67.00	Title V or XIX swing-bed NF inpatient routing (line 12 x line 19)	e costs through	December 31 (or the cost r	eporting period	0	67. 00
68. 00	Title V or XIX swing-bed NF inpatient routing (line 13 x line 20)	e costs after De	cember 31 of	the cost rep	orting period	0	68. 00
69. 00	Total title V or XIX swing-bed NF inpatient					0	69. 00
70. 00	PART III - SKILLED NURSING FACILITY, OTHER NU Skilled nursing facility/other nursing facil)		70.00
71. 00 72. 00	Adjusted general inpatient routine service c Program routine service cost (line 9 x line	ost per diem (li					71. 00 72. 00
73. 00	Medically necessary private room cost applications	,	(line 14 x li	ne 35)			73.00
74. 00 75. 00	Total Program general inpatient routine serv Capital-related cost allocated to inpatient				Part II column		74. 00 75. 00
	26, line 45)			ioi konoot bi	a. t . i , ooi a		
76. 00 77. 00	Per diem capital-related costs (line 75 ÷ li Program capital-related costs (line 9 x line						76. 00 77. 00
78. 00 79. 00	Inpatient routine service cost (line 74 minu Aggregate charges to beneficiaries for exces		ovi der record	le)			78. 00 79. 00
80.00	Total Program routine service costs for comp	arison to the co			nus line 79)		80.00
81. 00 82. 00	Inpatient routine service cost per diem limi Inpatient routine service cost limitation (I						81. 00 82. 00
83.00	Reasonable inpatient routine service costs (see instructions					83. 00
84. 00 85. 00	Program inpatient ancillary services (see in Utilization review - physician compensation		s)				84. 00 85. 00
86. 00	Total Program inpatient operating costs (sum PART IV - COMPUTATION OF OBSERVATION BED PASS	of lines 83 thr					86. 00
87. 00	Total observation bed days (see instructions					0	87. 00
	Adjusted general inpatient routine cost per	and the second s	and the second s				88.00

Health Financial Systems	ST. JOSEPH HOSPITA	L & HEALTH CENT	TER	In Lie	eu of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der CO		Peri od:	Worksheet D-1	
		Component (From 07/01/2017 To 06/30/2018		
		Title	: XVIII	Subprovi der - I RF	PPS	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observati on	
		(from line 21)	column 2	Observati on	Bed Pass	
				Bed Cost (from	Through Cost	
				line 89)	(col. 3 x col.	
					4) (see	
					instructions)	
	1.00	2.00	3. 00	4. 00	5. 00	
COMPUTATION OF OBSERVATION BED PASS THROU	JGH COST					
90.00 Capital -related cost	234, 554	3, 002, 694	0. 07811	5 0	0	90.00
91.00 Nursing School cost		3, 002, 694	0.00000	0	0	91.00
92.00 Allied health cost		3, 002, 694	0.00000	0 0	0	92.00
93.00 All other Medical Education		3, 002, 694	0.00000	0 0	0	93. 00

Health Financial Systems	ST. JOSEPH HOSP!	ITAL & HEALTH CENTER	In Lie	u of Form CMS-2	552-10
COMPUTATION OF INPATIENT OPERATIN	G COST	Provider CCN: 15-0010	Peri od:	Worksheet D-1	
			From 07/01/2017 To 06/30/2018	Date/Time Prep 11/26/2018 12:	
		Title XIX	Hospi tal	Cost	
Cost Center Descripti	on				
				1. 00	
PART I - ALL PROVIDER COMPO	ONENTS				
I NPATI ENT DAYS					
1.00 Inpatient days (including	private room days and swing-be	ed days, excluding newborn)		15, 779	1.00
2.00 Inpatient days (including	private room days, excluding s	swing-bed and newborn days)		15, 779	2.00
3 00 Private room days (excludi	ng swing-hed and observation b	ned days) If you have only nr	ivate room days	ام	3 00

	litle XIX Hospital	LOST	
	Cost Center Description	1. 00	
	PART I - ALL PROVIDER COMPONENTS	1.00	
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	15, 779	1.00
2. 00 3. 00	Inpatient days (including private room days, excluding swing-bed and newborn days) Private room days (excluding swing-bed and observation bed days). If you have only private room days,	15, 779 0	2. 00 3. 00
3.00	In value from days, (excluding swing-bed and observation bed days). If you have only private room days,	O	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)	14, 748	4. 00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost	0	5. 00
6. 00	reporting period Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost	0	6. 00
0.00	reporting period (if calendar year, enter 0 on this line)	O	0.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost	0	7. 00
	reporting period	_	
8. 00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	8. 00
9. 00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and	190	9. 00
	newborn days)		
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days)	0	10.00
11. 00	through December 31 of the cost reporting period (see instructions) Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after	0	11. 00
11.00	December 31 of the cost reporting period (if calendar year, enter 0 on this line)	O	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days)	0	12. 00
40.00	through December 31 of the cost reporting period		40.00
13. 00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	13. 00
14. 00	Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	14. 00
15. 00	Total nursery days (title V or XIX only)	2, 162	
16. 00	Nursery days (title V or XIX only)	51	16. 00
17 00	SWING BED ADJUSTMENT Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost	0.00	17 00
17. 00	reporting period	0. 00	17. 00
18. 00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost	0.00	18. 00
	reporting period		
19. 00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	0. 00	19. 00
20. 00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost	0.00	20. 00
	reporting period		
21. 00	Total general inpatient routine service cost (see instructions)	14, 780, 623	
22. 00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)	0	22. 00
23. 00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6	0	23. 00
	x line 18)		
24. 00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)	0	24. 00
25. 00	X Time 19) Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8	0	25. 00
20.00	x line 20)	· ·	20.00
26. 00	Total swing-bed cost (see instructions)	0	26. 00
27. 00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	14, 780, 623	27. 00
28. 00	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT General inpatient routine service charges (excluding swing-bed and observation bed charges)	0	28. 00
29. 00		0	
30.00	Semi -pri vate room charges (excluding swing-bed charges)	0	30. 00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0. 000000	31.00
32. 00 33. 00	Average private room per diem charge (line 29 ÷ line 3) Average semi-private room per diem charge (line 30 ÷ line 4)	0. 00 0. 00	32. 00 33. 00
34. 00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)	0.00	34.00
35. 00	Average per diem private room cost differential (line 34 x line 31)	0.00	35. 00
36. 00	Private room cost differential adjustment (line 3 x line 35)	0	36. 00
37. 00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line	14, 780, 623	37. 00
	27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY		
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS		
38. 00	Adjusted general inpatient routine service cost per diem (see instructions)	936. 73	
39.00	Program general inpatient routine service cost (line 9 x line 38)	177, 979	39.00
40. 00 41. 00	Medically necessary private room cost applicable to the Program (line 14 x line 35) Total Program general inpatient routine service cost (line 39 + line 40)	0 177, 979	40.00
4 1. 00	Trotal Trogram general impatient routine service cost (Illie 37 + Illie 40)	1//, 7/9	1 + 1. UU

7.00	Total swing-bed in type impatrent days (including private room days) through becember 31 of the cost	U	7.00
0.00	reporting period	0	0.00
8. 00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost	0	8. 00
0.00	reporting period (if calendar year, enter 0 on this line)	190	0.00
9. 00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)	190	9. 00
10. 00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days)	0	10. 00
10.00	through December 31 of the cost reporting period (see instructions)	O	10.00
11. 00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after	0	11. 00
11.00	December 31 of the cost reporting period (if calendar year, enter 0 on this line)	O	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days)	0	12. 00
	through December 31 of the cost reporting period	_	
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days)	0	13. 00
	after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	14. 00
15.00	Total nursery days (title V or XIX only)	2, 162	15. 00
16.00	Nursery days (title V or XIX only)	51	16. 00
	SWING BED ADJUSTMENT		
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost	0.00	17. 00
	reporting period		
18. 00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost	0.00	18. 00
	reporting period		
19. 00	Medical drate for swing-bed NF services applicable to services through December 31 of the cost	0. 00	19. 00
00.00	reporting period	0.00	00.00
20. 00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost	0. 00	20. 00
21. 00	reporting period	14, 780, 623	21. 00
	Total general inpatient routine service cost (see instructions)	14, 780, 623	
22. 00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)	Ü	22.00
23. 00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6)	0	23. 00
23.00	Swing-bed cost approximate to swintype services after becember 31 of the cost reporting period (fine b	O	23.00
24. 00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line	0	24. 00
24.00	7 x Line 19)	O	24.00
25. 00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8	0	25. 00
	x line 20)	_	
26.00	Total swing-bed cost (see instructions)	0	26. 00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	14, 780, 623	27. 00
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)	0	28. 00
29.00	Private room charges (excluding swing-bed charges)	0	29. 00
30.00	Semi-private room charges (excluding swing-bed charges)	0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0.000000	31. 00
32.00	Average private room per diem charge (line 29 ÷ line 3)	0.00	
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)	0.00	33. 00
	Average per diem private room charge differential (line 32 minus line 33)(see instructions)	0.00	
	Average per diem private room cost differential (line 34 x line 31)	0.00	
36.00	Private room cost differential adjustment (line 3 x line 35)	0	
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line	14, 780, 623	37. 00
	27 minus line 36)		
	PART II - HOSPITAL AND SUBPROVIDERS ONLY		
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS	201 ==	
	Adjusted general inpatient routine service cost per diem (see instructions)	936. 73	
	Program general inpatient routine service cost (line 9 x line 38)	177, 979	
	Medically necessary private room cost applicable to the Program (line 14 x line 35)	177 070	
41.00	Total Program general inpatient routine service cost (line 39 + line 40)	177, 979	41.00

	Financial Systems ST. TATION OF INPATIENT OPERATING COST	JOSEPH HOSPITAL	& HEALTH CENT		In Lie	worksheet D-1	
CUMPU	ATTON OF INPATTENT OPERATING COST		Provider Co	N: 15-0010	From 07/01/2017 To 06/30/2018		
						11/26/2018 12	
	Coot Contan Decement on	Total	Ti tl Total	e XIX Average Per	Hospital Program Days	Cost Program Cost	
	Cost Center Description	Inpatient Cost				(col. 3 x col.	
		1.00	2. 00	3. 00	4. 00	5. 00	
2. 00	NURSERY (title V & XIX only)	1, 227, 483	2, 162	567.	75 51	28, 955	42.0
13. 00	Intensive Care Type Inpatient Hospital Units INTENSIVE CARE UNIT	3, 254, 991	1, 812	1, 796.	35 257	461, 662	43. C
4. 00	CORONARY CARE UNIT	0,201,771	1,012	1,770.	207	101,002	44. 0
15.00	BURN INTENSIVE CARE UNIT						45. C
16.00	SURGICAL INTENSIVE CARE UNIT						46.0
17.00	OTHER SPECIAL CARE (SPECIFY) Cost Center Description						47.0
		_				1. 00	
8. 00	Program inpatient ancillary service cost (W			>		3, 696, 530	
19. 00	Total Program inpatient costs (sum of lines PASS THROUGH COST ADJUSTMENTS	41 through 48)(s	see instructio	ns)		4, 365, 126	J 49. C
0.00	Pass through costs applicable to Program in	patient routine s	services (from	Wkst. D, su	m of Parts I and	0	50. C
-1 00			/ 6	Wi! D	ED ! !!	_	[4 4
51. 00	Pass through costs applicable to Program in and IV)	batient ancillary	services (fr	om WKSt. D,	sum or Parts II	0	51.0
52. 00	Total Program excludable cost (sum of lines	50 and 51)				0	52.0
3. 00	Total Program inpatient operating cost excl		ated, non-phy	sician anest	hetist, and	0	53.0
	medical education costs (line 49 minus line TARGET AMOUNT AND LIMIT COMPUTATION	52)					
4. 00						0	54.0
5. 00	Target amount per discharge					0.00	55.0
6.00	Target amount (line 54 x line 55)	ting oost and tar	ast smount (1	ina E/ minua	Line E2)	0	
7. 00 8. 00	Difference between adjusted inpatient operations payment (see instructions)	tring cost and tar	get amount (i	THE 56 III HUS	11 ne 53)	0	
9. 00	Lesser of lines 53/54 or 55 from the cost re	eporting period e	ending 1996, u	pdated and c	ompounded by the	_	
0 00	market basket					0.00	,,,
0. 00 1. 00	Lesser of lines 53/54 or 55 from prior year If line 53/54 is less than the lower of line					0.00	1
00	which operating costs (line 53) are less that						
	amount (line 56), otherwise enter zero (see	instructions)					/
52. 00 53. 00	Relief payment (see instructions) Allowable Inpatient cost plus incentive pay	ment (see instruc	ctions)			0	
30.00	PROGRAM INPATIENT ROUTINE SWING BED COST	(333 111311 43	711 0110)]
54. 00	3	sts through Decem	ber 31 of the	cost report	ing period (See	0	64. C
55. 00	<pre>instructions)(title XVIII only) Medicare swing-bed SNF inpatient routine co</pre>	sts after Decembe	er 31 of the c	ost reportin	a period (See	0	65. C
, , , ,	instructions) (title XVIII only)	313 a. 13. 333333	0. 0 0	оот горог и п	g po ou (oco		
6. 00	Total Medicare swing-bed SNF inpatient rout	ne costs (line 6	4 plus line 6	5)(title XVI	II only). For	0	66.0
57. 00	CAH (see instructions) Title V or XIX swing-bed NF inpatient routing	ne costs through	December 31 o	f the cost r	eporting period	0	67.0
	(line 12 x line 19)				-p-:g p-:		
58. 00	Title V or XIX swing-bed NF inpatient routing	ne costs after De	ecember 31 of	the cost rep	orting period	0	68.0
59. 00	(line 13 x line 20) Total title V or XIX swing-bed NF inpatient	routine costs (I	ine 67 + line	68)		0	69.0
	PART III - SKILLED NURSING FACILITY, OTHER N						
70.00	Skilled nursing facility/other nursing facil)		70.0
71. 00 72. 00	Adjusted general inpatient routine service of Program routine service cost (line 9 x line	,	ne 70 ÷ 11ne	2)			71. C
3. 00	Medically necessary private room cost applic	•	(line 14 x li	ne 35)			73.0
74.00	Total Program general inpatient routine serv	,					74. C
75. 00	Capital-related cost allocated to inpatient 26, line 45)	routine service	costs (from W	orksheet B,	Part II, column		75. C
6. 00	Per diem capital-related costs (line 75 ÷ 1)	ne 2)					76.0
7. 00	,						77.0
8. 00 9. 00	Inpatient routine service cost (line 74 mine Aggregate charges to beneficiaries for excess		ovidor record	c)			78.0
0.00	Total Program routine service costs for com			· .	nus line 79)		80.0
1. 00	Inpatient routine service cost per diem lim	tati on		•	ŕ		81.0
2. 00	Inpatient routine service cost limitation (82. 0
4.00	Reasonable inpatient routine service costs Program inpatient ancillary services (see in	•	·)				84. (
35. 00	Utilization review - physician compensation		ıs)				85.0
36. 00	Total Program inpatient operating costs (sur		ough 85)				86.0
37. 00	PART IV - COMPUTATION OF OBSERVATION BED PASTOTAL observation bed days (see instructions					1, 031	 87. 0
38. 00	, ·	•	line 2)			936. 73	1
,0. 00		ee instructions)				965, 769	

Health Financial Systems S	. JOSEPH HOSPITA	L & HEALTH CENT	ER	In Lie	eu of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der Co		Peri od:	Worksheet D-1	
				From 07/01/2017 To 06/30/2018	Date/Time Pre 11/26/2018 12	
		Titl	e XIX	Hospi tal	Cost	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observati on	
		(from line 21)	column 2	Observati on	Bed Pass	
				Bed Cost (from	Through Cost	
				line 89)	(col. 3 x col.	
					4) (see	
					instructions)	
	1.00	2.00	3. 00	4. 00	5. 00	
COMPUTATION OF OBSERVATION BED PASS THROUG	H COST					
90.00 Capital -related cost	917, 542	14, 780, 623	0. 06207	7 965, 769	59, 952	90. 00
91.00 Nursing School cost	C	14, 780, 623	0. 000000	965, 769	0	91.00
92.00 Allied health cost	C	14, 780, 623	0. 000000	965, 769	0	92. 00
93.00 All other Medical Education	c	14, 780, 623	0. 000000	965, 769	0	93. 00

Health Financial Systems	ST. JOSEPH HOSPITAL &	HEALTH CENTER	In Lie	u of Form CMS-2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 15-0010		Worksheet D-1
		Component CCN: 15-T010	From 07/01/2017 To 06/30/2018	Date/Time Prepared: 11/26/2018 12:03 pm
		Title XIX	Subprovi der -	Cost

		II the XIX	IRF	COST	
	Cost Center Description			1.00	
	PART I - ALL PROVIDER COMPONENTS			1. 00	
	I NPATI ENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days			3, 547	1. 00
2.00	Inpatient days (including private room days, excluding swing-k			3, 547	2.00
3. 00	Private room days (excluding swing-bed and observation bed day do not complete this line.	(s). If you have only pri	vate room days,	0	3. 00
4.00	Semi-private room days (excluding swing-bed and observation be	ed days)		3, 547	4. 00
5.00	Total swing-bed SNF type inpatient days (including private roo		r 31 of the cost	0	5. 00
	reporting period				
6. 00	Total swing-bed SNF type inpatient days (including private room	om days) after December 3	31 of the cost	0	6. 00
7. 00	reporting period (if calendar year, enter 0 on this line) Total swing-bed NF type inpatient days (including private room	days) through December	31 of the cost	0	7. 00
,, ,,	reporting period	. aayo, eoag. booobo.	0. 0. 1 0001	,	,,,,,
8.00	Total swing-bed NF type inpatient days (including private room	n days) after December 3°	1 of the cost	0	8. 00
0.00	reporting period (if calendar year, enter 0 on this line)	. +b - D (i bii	1.5	0.00
9. 00	Total inpatient days including private room days applicable to newborn days)	the Program (excluding	swing-bed and	15	9. 00
10. 00	Swing-bed SNF type inpatient days applicable to title XVIII or	nly (including private ro	oom days)	0	10.00
	through December 31 of the cost reporting period (see instruct				
11. 00	Swing-bed SNF type inpatient days applicable to title XVIII or		oom days) after	0	11. 00
12. 00	December 31 of the cost reporting period (if calendar year, er Swing-bed NF type inpatient days applicable to titles V or XI)		e room days)	0	12. 00
12.00	through December 31 of the cost reporting period	comy (The daing private	c room days)	, °	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XI)			0	13. 00
44.00	after December 31 of the cost reporting period (if calendar ye				44.00
14. 00 15. 00	Medically necessary private room days applicable to the Progra Total nursery days (title V or XIX only)	am (excluding swing-bed o	days)	2 162	14. 00 15. 00
16. 00	Nursery days (title V or XIX only)			51	16. 00
	SWING BED ADJUSTMENT			3.	10.00
17. 00	Medicare rate for swing-bed SNF services applicable to service	es through December 31 o	f the cost	0.00	17. 00
18. 00	reporting period	os after December 21 of	the cost	0.00	18. 00
10.00	Medicare rate for swing-bed SNF services applicable to service reporting period	es arter becember 31 or	the cost	0.00	16.00
19. 00	Medicaid rate for swing-bed NF services applicable to services	through December 31 of	the cost	0.00	19. 00
	reporting period	-			
20. 00	Medicaid rate for swing-bed NF services applicable to services	after December 31 of the	ne cost	0. 00	20. 00
21. 00	reporting period Total general inpatient routine service cost (see instructions			3, 002, 694	21. 00
22. 00	Swing-bed cost applicable to SNF type services through December		ng period (line	0	22. 00
	5 x line 17)				
23. 00	Swing-bed cost applicable to SNF type services after December	31 of the cost reporting	g period (line 6	0	23. 00
24. 00	x line 18) Swing-bed cost applicable to NF type services through December	31 of the cost reportion	na period (line	0	24. 00
	7 x line 19)		.g p (
25. 00		31 of the cost reporting	period (line 8	0	25. 00
26. 00	x line 20) Total swing-bed cost (see instructions)			0	26. 00
27. 00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)		3, 002, 694	
27.00	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT	21		0,002,071	27.00
	General inpatient routine service charges (excluding swing-bed	and observation bed cha	arges)		28. 00
29. 00	Private room charges (excluding swing-bed charges)			0	29. 00
30. 00 31. 00	Semi-private room charges (excluding swing-bed charges) General inpatient routine service cost/charge ratio (line 27 -	line 28)		0. 000000	30. 00 31. 00
32. 00	Average private room per diem charge (line 29 ÷ line 3)	11116 20)		0. 00	
33. 00	Average semi-private room per diem charge (line 30 ÷ line 4)			0.00	
34.00	Average per diem private room charge differential (line 32 mir	, ,	tions)	0.00	
35. 00	Average per diem private room cost differential (line 34 x line)	ne 31)		0.00	
36. 00 37. 00	Private room cost differential adjustment (line 3 x line 35) General inpatient routine service cost net of swing-bed cost a	and private room cost di	fferential (line	0 3, 002, 694	36. 00 37. 00
37.00	27 minus line 36)	ina private room cost dr	irorential (IIIIe	3, 002, 094	37.00
	PART II - HOSPITAL AND SUBPROVIDERS ONLY				
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJU				
38. 00	Adjusted general inpatient routine service cost per diem (see			846. 54	
39. 00 40. 00	Program general inpatient routine service cost (line 9 x line Medically necessary private room cost applicable to the Program			12, 698 0	39. 00 40. 00
	Total Program general inpatient routine service cost (line 39	•		12, 698	
	j - j - j - j - j - j - j - j - j - j -	/	ļ	.=, =, 0	

		JOSEPH HOSPITAL				eu of Form CMS-2	
COMPUT	ATION OF INPATIENT OPERATING COST			CCN: 15-0010 CCN: 15-T010	Period: From 07/01/2017 To 06/30/2018	Date/Time Pre	pared:
			Ti ti	le XIX	Subprovi der -	11/26/2018 12 Cost	:03 pm
	Cost Center Description	Total	Total	Average Per	IRF Program Days	Program Cost	
	·	(col. 3 x col. 4)					
42 00	NURSERY (title V & XIX only)	1.00	2.00	3.00	4.00	5.00	42, 00
	Intensive Care Type Inpatient Hospital Units						
43. 00 44. 00	INTENSIVE CARE UNIT CORONARY CARE UNIT	0	(0. (00 0	0	43. 00 44. 00
45. 00	BURN INTENSIVE CARE UNIT SURGICAL INTENSIVE CARE UNIT						45. 00
46. 00 47. 00	OTHER SPECIAL CARE (SPECIFY)						46. 00 47. 00
	Cost Center Description					1.00	
48. 00	Program inpatient ancillary service cost (Wk					19, 522	1
49. 00	Total Program inpatient costs (sum of lines PASS THROUGH COST ADJUSTMENTS					32, 220	49. 00
50. 00	Pass through costs applicable to Program inpa	atient routine	services (from	m Wkst. D, sur	n of Parts I and	0	50.00
51. 00	Pass through costs applicable to Program inpland IV)	atient ancillar	y services (fi	rom Wkst. D, s	sum of Parts II	0	51. 00
52. 00 53. 00	Total Program excludable cost (sum of lines ! Total Program inpatient operating cost exclu		lated non	releion anacti	notict and	0	
53.00	medical education costs (line 49 minus line ! TARGET AMOUNT AND LIMIT COMPUTATION		rated, non-phy	ysi ci ani anesti	netrst, and	0	53.00
54. 00	Program di scharges					0	
55. 00 56. 00	Target amount per discharge Target amount (line 54 x line 55)					0.00	55. 00 56. 00
57. 00	Difference between adjusted inpatient operat	ng cost and ta	rget amount (I	ine 56 minus	line 53)	0	57. 00
58. 00 59. 00	Bonus payment (see instructions) Lesser of lines 53/54 or 55 from the cost re	porting period	endi na 1996. u	updated and co	ompounded by the	0.00	
	market basket	0.	<u> </u>	•	. ,	0.00	
60.00 Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket 61.00 If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by							60. 00 61. 00
which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)							
62. 00 63. 00	Relief payment (see instructions) Allowable Inpatient cost plus incentive paym	ent (see instru	ctions)			0	
	PROGRAM INPATIENT ROUTINE SWING BED COST Medicare swing-bed SNF inpatient routine cos			a agat mananti	na noriad (Coo		64.00
64. 00	instructions)(title XVIII only)	3		•			
65. 00	Medicare swing-bed SNF inpatient routine cosinstructions)(title XVIII only)	is after Decemb	er 31 or the (cost reportin	g period (See	0	65. 00
66. 00	Total Medicare swing-bed SNF inpatient routil CAH (see instructions)		•		•	0	
67. 00	Title V or XIX swing-bed NF inpatient routing (line 12 x line 19)	e costs through	December 31 o	of the cost re	eporting period	0	67. 00
68. 00	Title V or XIX swing-bed NF inpatient routing (line 13 x line 20)	e costs after D	ecember 31 of	the cost repo	orting period	0	68. 00
69. 00	Total title V or XIX swing-bed NF inpatient PART III - SKILLED NURSING FACILITY, OTHER NU					0	69. 00
70. 00 71. 00	Skilled nursing facility/other nursing facil Adjusted general inpatient routine service of	ty/ICF/IID rou	tine service (cost (line 37))		70. 00 71. 00
72. 00	Program routine service cost (line 9 x line	71)					72. 00
73. 00 74. 00	Medically necessary private room cost applications and program general inpatient routine services.		•				73. 00 74. 00
75. 00	Capital-related cost allocated to inpatient 26, line 45)	•			Part II, column		75. 00
76.00	Per diem capital-related costs (line 75 ÷ li	. *					76.00
77. 00 78. 00	Program capital-related costs (line 9 x line Inpatient routine service cost (line 74 minus						77. 00 78. 00
79.00	79.00 Aggregate charges to beneficiaries for excess costs (from provider records)						79. 00 80. 00
80.00	80.00 Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79) 81.00 Inpatient routine service cost per diem limitation						80.00
82. 00 83. 00	Inpatient routine service cost limitation (I Reasonable inpatient routine service costs (* .				82. 00 83. 00
84. 00	Program inpatient ancillary services (see in	structions)					84. 00
85. 00 86. 00	Utilization review - physician compensation Total Program inpatient operating costs (sum						85. 00 86. 00
	PART IV - COMPUTATION OF OBSERVATION BED PASS	THROUGH COST	49 50/				1
87. 00 88. 00	Total observation bed days (see instructions Adjusted general inpatient routine cost per		line 2)			0.00	87. 00 88. 00
89. 00	Observation bed cost (line 87 x line 88) (see	e instructions)				0	89. 00

Health Financial Systems	ST. JOSEPH HOSPITA	L & HEALTH CENT	TER	In Lie	eu of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der Co		Peri od:	Worksheet D-1	
		Component (From 07/01/2017 To 06/30/2018		
		Ti tl	e XIX	Subprovi der - I RF	Cost	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observati on	
		(from line 21)	column 2	Observati on	Bed Pass	
				Bed Cost (from	Through Cost	
				line 89)	(col. 3 x col.	
					4) (see	
					instructions)	
	1.00	2.00	3.00	4. 00	5. 00	
COMPUTATION OF OBSERVATION BED PASS THROU	GH COST					
90. 00 Capi tal -rel ated cost	234, 554	3, 002, 694	0. 07811	5 0	0	90.00
91.00 Nursing School cost	C	3, 002, 694	0.00000	0	0	91.00
92.00 Allied health cost	C	3, 002, 694	0.00000	0 0	0	92.00
93.00 All other Medical Education	C	3, 002, 694	0.00000	0 0	0	93. 00

Health Financial Systems ST. JOSEPH HOSPITAL	& HEALTH CENT	ΓER	In Lie	eu of Form CMS-2	2552-10
INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provi der Co	CN: 15-0010	Peri od:	Worksheet D-3	
			From 07/01/2017		
			To 06/30/2018	Date/Time Pre 11/26/2018 12	pared:
	Ti +l c	xVIII	Hospi tal	PPS	. US PIII
Cost Center Description	11110	Ratio of Cos		Inpati ent	
oust defited beset per on		To Charges	Program	Program Costs	
		l ro onar goo	Charges	(col. 1 x col.	
			January gra	2)	
		1.00	2. 00	3. 00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30. 00 03000 ADULTS & PEDI ATRI CS			9, 990, 111		30. 00
31.00 03100 INTENSIVE CARE UNIT			3, 642, 160		31.00
41. 00 04100 SUBPROVI DER - RF			0		41. 00
43. 00 04300 NURSERY					43.00
ANCILLARY SERVICE COST CENTERS					
50.00 05000 OPERATING ROOM		0. 14545			50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM		0. 24895	55, 359	13, 782	52. 00
54. 00 05400 RADI OLOGY-DI AGNOSTI C		0. 22306			
54. 01 03630 ULTRA SOUND		0. 09032		41, 176	
56. 00 05600 RADI 0I SOTOPE		0. 10708			
57. 00 05700 CT SCAN		0. 07919			
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)		0. 20107			
59. 00 05900 CARDI AC CATHETERI ZATI ON		0. 16336			59. 00
60. 00 06000 LABORATORY		0. 11602			
65. 00 06500 RESPI RATORY THERAPY		0. 20446			65. 00
66. 00 06600 PHYSI CAL THERAPY		0. 33445			
67. 00 06700 OCCUPATI ONAL THERAPY		0. 37355			
68. 00 06800 SPEECH PATHOLOGY		0. 43992			1
69. 00 06900 ELECTROCARDI OLOGY		0. 11227			1
70. 00 07000 ELECTROENCEPHALOGRAPHY		0. 16777			1
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		0. 17134			71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS		0. 30154			72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS		0. 43221			73. 00
74. 00 07400 RENAL DI ALYSI S		1. 51465			74. 00
76. 00 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES		0. 44481		0	76. 00
76. 01 03190 CHEMOTHERAPY		1. 38287			76. 01
76. 02 03330 ENDOSCOPY		0. 14513			76. 02
76. 03 03950 WOUND CARE CENTER		0. 09761	1 0	0	76. 03

0.083279

0. 418340

5, 737, 571 269, 212

57, 070, 230

57, 070, 230

477, 819 112, 622

10, 937, 144 200. 00 201. 00

91.00

92.00

95.00

202. 00

OUTPATIENT SERVICE COST CENTERS

92. 00 O9200 OBSERVATION BEDS (NON-DISTINCT PART)
OTHER REIMBURSABLE COST CENTERS

Net charges (line 200 minus line 201)

Total (sum of lines 50 through 94 and 96 through 98)
Less PBP Clinic Laboratory Services-Program only charges (line 61)

09100 EMERGENCY

95. 00 09500 AMBULANCE SERVICES

91.00

200. 00 201. 00

202.00

Component CCN: 15-T010 From 07/01/2017 Date/Time Prepare 11/26/2018 12: 0
Title XVIII Subprovider - IRF
Ratio of Cost Inpatient Program Cost Charges Cost
Charges (col. 1 x col. 2)
2 2 1.00 2.00 3.00 2.00 2.00
1.00 2.00 3.00
PATIENT ROUTINE SERVICE COST CENTERS 000 ADULTS & PEDIATRICS 100 INTENSIVE CARE UNIT 100 SUBPROVIDER - IRF 300 NURSERY CILLARY SERVICE COST CENTERS 000 OPERATING ROOM 100 OPERATIN
100 INTENSIVE CARE UNIT
100 SUBPROVI DER - I RF
300 NURSERY
CILLARY SERVICE COST CENTERS 000 OPERATI NG ROOM 0. 145457 56, 155 8, 168 200 DELI VERY ROOM & LABOR ROOM 0. 248956 0 0
000 OPERATI NG ROOM 0. 145457 56, 155 8, 168 200 DELI VERY ROOM & LABOR ROOM 0. 248956 0 0
200 DELIVERY ROOM & LABOR ROOM 0. 248956 0 0 0
400 RADI OLOGY - DI AGNOSTI C 0. 223063 75, 827 16, 914
630 ULTRA SOUND 0. 090323 5, 728 517
600 RADI 0I SOTOPE 0. 107082 0 0 0
700 CT SCAN 0. 079194 27, 200 2, 154
800 MAGNETIC RESONANCE I MAGING (MRI) 0. 201076 6, 650 1, 337
0. 100000
000 LABORATORY 0. 116029 1, 143, 957 132, 732 500 RESPI RATORY THERAPY 0. 204461 399, 648 81, 712
600 PHYSI CAL THERAPY 0. 334459 1, 206, 028 403, 367
700 OCCUPATI ONAL THERAPY 0. 373557 1, 206, 026 403, 367 7
800 SPEECH PATHOLOGY 0. 439925 163, 235 71, 811
900 ELECTROCARDI OLOGY 0. 112278 16, 652 1, 870
000 ELECTROENCEPHALOGRAPHY 0. 167778 3, 348 562
100 MEDI CAL SUPPLIES CHARGED TO PATIENTS 0. 171343 246, 699 42, 270
200 I MPL. DEV. CHARGED TO PATIENTS 0. 301548 13, 920 4, 198
300 DRUGS CHARGED TO PATIENTS 0. 432219 510, 377 220, 595
400 RENAL DIALYSIS 1. 514658 19, 684 29, 815
550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES 0. 444811 0 0
190 CHEMOTHERAPY 1. 382876 0 0
330 ENDOSCOPY 0. 145136 0 0 0
950 WOUND CARE CENTER 0. 097611 0 0
TPATIENT SERVICE COST CENTERS
100 EMERGENCY 0. 083279 0 0
200 OBSERVATI ON BEDS (NON-DI STINCT PART) 0. 418340 0 0
HER REI MBURSABLE COST CENTERS
500 AMBULANCE SERVICES
Total (sum of lines 50 through 94 and 96 through 98) 4, 930, 391 1, 404, 759 2
Less PBP Clinic Laboratory Services-Program only charges (line 61) Net charges (line 200 minus line 201) 0 20 4,930,391
Net charges (line 200 minus line 201) 4,930,391

Heal th	Financial Systems ST. JOSEPH HOSPITAL &	HEALTH CENT	TER	In Lie	eu of Form CMS-2	2552-10
INPATI	ENT ANCILLARY SERVICE COST APPORTIONMENT	Provi der Co	CN: 15-0010	Peri od:	Worksheet D-3	
				From 07/01/2017	5 . (7)	
				To 06/30/2018	Date/Time Prep 11/26/2018 12	pared:
		Ti +I	e XIX	Hospi tal	Cost	. 03 piii
	Cost Center Description		Ratio of Cos		Inpati ent	
			To Charges	Program	Program Costs	
			J		(col. 1 x col.	
					2)	
			1.00	2. 00	3. 00	
	INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000 ADULTS & PEDI ATRI CS			5, 572, 345		30. 00
31.00	03100 I NTENSI VE CARE UNI T			31, 707		31. 00
41.00	04100 SUBPROVI DER - I RF			0		41. 00
43.00	04300 NURSERY			2, 027, 718		43.00
	ANCILLARY SERVICE COST CENTERS					
	05000 OPERATI NG ROOM		0. 14545			
	05200 DELIVERY ROOM & LABOR ROOM		0. 24895			
	05400 RADI OLOGY-DI AGNOSTI C		0. 22306	- 1		
	03630 ULTRA SOUND		0. 09032			
	05600 RADI 0I S0T0PE		0. 10636			56. 00
57. 00	lo5700LCT SCAN		0. 07919	221, 635	17, 552	1 57. 00

51, 203

78, 421

3, 794, 777

849, 750

203, 037

72, 574

18, 092

183, 634

16, 947

547, 518

694, 583

15, 548

14, 917

31, 720

60,002

1, 231, 478

18, 033, 644

18, 033, 644

3, 111

1, 702, 515

10, 296

12, 811

440, 304

173, 741

67, 908

27, 111

7, 959

20, 618

93, 813

209, 450

735, 859

23, 550

20, 628

1, 384

4,604

5, 857

102, 556

3, 696, 530

2, 843

58.00

59.00

60.00

65.00

66 00

67.00

68.00

69.00

70 00

71.00

72.00

73 00

74.00

76.00

76.01

76.02

76.03

91.00

0 92.00

95.00

200. 00

201. 00

202. 00

0. 201076

0.163360

0.116029

0. 204461

0.334459

0. 373557

0.439925

0.112278

0. 167778

0.171343

0.301548

0.432219

1.514658

0.444811

1.382876

0.145136

0.097611

0.083279

0.418340

58. 00 05800 MAGNETIC RESONANCE I MAGING (MRI)

05900 CARDIAC CATHETERIZATION

06500 RESPIRATORY THERAPY

06700 OCCUPATI ONAL THERAPY

07000 ELECTROENCEPHALOGRAPHY

07300 DRUGS CHARGED TO PATIENTS

OUTPATIENT SERVICE COST CENTERS

OTHER REIMBURSABLE COST CENTERS

07100 MEDICAL SUPPLIES CHARGED TO PATIENTS

03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES

09200 OBSERVATION BEDS (NON-DISTINCT PART)

Net charges (line 200 minus line 201)

Total (sum of lines 50 through 94 and 96 through 98)

Less PBP Clinic Laboratory Services-Program only charges (line 61)

07200 IMPL. DEV. CHARGED TO PATIENTS

06600 PHYSI CAL THERAPY

06800 SPEECH PATHOLOGY

06900 ELECTROCARDI OLOGY

07400 RENAL DIALYSIS

03950 WOUND CARE CENTER

09500 AMBULANCE SERVICES

03190 CHEMOTHERAPY

03330 ENDOSCOPY

09100 EMERGENCY

06000 LABORATORY

59.00

60.00

65.00

66 00

67.00

68.00

69.00

70 00

71.00

72.00

73 00

74.00

76.00

76. 01

76.02

76.03

91.00

92.00

95.00

200.00

201.00

202.00

	Financial Systems ST. JOSEPH HOSPITAL & ENT ANCILLARY SERVICE COST APPORTIONMENT		CN: 15-0010	Peri od:		worksheet D-3	
		Component	CCN: 15-T010	From 07/01/ To 06/30/		Date/Time Pre	narod:
		Component	CCN. 15-1010			11/26/2018 12	
		Ti tl	e XIX	Subprovi de I RF	r -	Cost	
	Cost Center Description		Ratio of Cos			Inpati ent	
			To Charges	Prograi Charge:		Program Costs (col. 1 x col.	
				orial ge.	,	2)	
			1.00	2. 00		3. 00	
	I NPATI ENT ROUTI NE SERVI CE COST CENTERS					Г	
30.00	03000 ADULTS & PEDIATRICS				0		30.00
31. 00 41. 00	03100 NTENSI VE CARE UNI T 04100 SUBPROVI DER - RF			122	0		31. 00 41. 00
	04300 NURSERY			133	, 671 0		43.00
43.00	ANCI LLARY SERVI CE COST CENTERS		<u> </u>				43.00
50. 00	05000 OPERATI NG ROOM		0. 1454	57	0	0	50.00
52. 00	05200 DELIVERY ROOM & LABOR ROOM		0. 2489		0	Ō	
54.00	05400 RADI OLOGY-DI AGNOSTI C		0. 2230	63	594	132	54.00
54. 01	03630 ULTRA SOUND		0. 0903	23	0	0	54. 01
56. 00	05600 RADI 0I SOTOPE		0. 1063	69	0	0	56.00
57. 00	05700 CT SCAN		0. 0791	94 1	, 154	91	57.00
58. 00	05800 MAGNETIC RESONANCE I MAGING (MRI)		0. 2010		0	0	
59. 00	05900 CARDI AC CATHETERI ZATI ON		0. 1633		0	0	
60.00	06000 LABORATORY		0. 1160		, 109	1, 637	
65.00	06500 RESPI RATORY THERAPY		0. 2044		, 525	1, 743	•
66.00	06600 PHYSI CAL THERAPY		0. 3344		, 439	9, 846	
67. 00 68. 00	06700 OCCUPATI ONAL THERAPY		0. 3735 0. 4399		, 952		67. 00 68. 00
69. 00	O6800 SPEECH PATHOLOGY O6900 ELECTROCARDI OLOGY		0. 4399		, 733	762 0	
70. 00	07000 ELECTROCARDI OLOGI 07000 ELECTROENCEPHALOGRAPHY		0. 1122		0	0	
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		0. 1713		0	Ö	
72. 00	07200 IMPL. DEV. CHARGED TO PATIENTS		0. 3015		0	0	
73. 00	07300 DRUGS CHARGED TO PATIENTS		0. 4322		, 279	2, 714	
74. 00	07400 RENAL DIALYSIS		1. 5146		. 0	0	
76. 00	03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES		0. 4448		0	0	76.00
76. 01	03190 CHEMOTHERAPY		1. 3828	76	0	0	76. 01
76. 02	03330 ENDOSCOPY		0. 1451	36	0	0	76. 02
76. 03	03950 WOUND CARE CENTER		0. 0976	11	0	0	76. 03
	OUTPATIENT SERVICE COST CENTERS			7.0			
	09100 EMERGENCY		0.0832		0	0	
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART) OTHER REIMBURSABLE COST CENTERS		0. 4183	40	0	0	92.00
95. 00	09500 AMBULANCE SERVICES						95. 00
200.00				69	, 785	19, 522	
200.00		s (Line 61)			, 703 N	17, 322	201. 00
201.00	Net charges (line 200 minus line 201)	5 (1110 01)	1	1	, 785	l	202.00

Health Financial Systems	ST. JOSEPH HOSPITAL &	HEALTH CENTER	In Lie	u of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 15-0010	Peri od: From 07/01/2017 To 06/30/2018	Worksheet E Part A Date/Time Prepared:

			10 00/30/2016	11/26/2018 12:	
		Title XVIII	Hospi tal	PPS	<u> </u>
			•		
				1. 00	
	PART A - INPATIENT HOSPITAL SERVICES UNDER IPPS				
1.00	DRG Amounts Other than Outlier Payments			0	1. 00
1. 01	DRG amounts other than outlier payments for discharges occurri	ing prior to October 1 (:	see	3, 640, 398	1. 01
	instructions)				
1. 02	DRG amounts other than outlier payments for discharges occurri	11, 148, 767	1. 02		
	instructions)				
1. 03	DRG for federal specific operating payment for Model 4 BPCI fo	or discharges occurring	orior to October	0	1. 03
1 04	1 (see instructions)	on disabangsa sasunning	an an aften	0	1 04
1. 04	DRG for federal specific operating payment for Model 4 BPCI for	or discharges occurring t	on or arter) 	1. 04
2.00	October 1 (see instructions) Outlier payments for discharges. (see instructions)			230, 116	2. 00
2.00	Outlier reconciliation amount			230, 110	2. 00
2. 01	Outlier payment for discharges for Model 4 BPCI (see instructi	one)		0	2.01
3. 00	, ,	UIS)		0	3.00
	Managed Care Simulated Payments	sting posied (occ instru	ationa)	-	ı
4. 00	Bed days available divided by number of days in the cost report	ting period (see instru	CLI ONS)	104. 18	4. 00
E 00	Indirect Medical Education Adjustment	t recent east reporting	and and an	0.00	F 00
5. 00	FTE count for allopathic and osteopathic programs for the mosor before 12/31/1996. (see instructions)	recent cost reporting	berroa enarng on	0. 00	5. 00
6. 00	FTE count for allopathic and osteopathic programs which meet	the criteria for an add	on to the can	0. 00	6. 00
6.00	for new programs in accordance with 42 CFR 413.79(e)	the criteria for all add-	on to the cap	0.00	0.00
7. 00	MMA Section 422 reduction amount to the IME cap as specified u	indon 42 CED 8412 105(f)	(1) (i y) (D) (1)	0.00	7. 00
7. 00	ACA § 5503 reduction amount to the IME cap as specified under			0.00	7. 00
7.01		42 CFR 9412. 105(1)(1)(1	V)(b)(2) II the	0.00	7.01
8. 00	cost report straddles July 1, 2011 then see instructions. Adjustment (increase or decrease) to the FTE count for allopations.	this and astaonathic pro-	arome for	0. 00	8. 00
8.00				0.00	0.00
	affiliated programs in accordance with 42 CFR 413.75(b), 413.7 1998), and 67 FR 50069 (August 1, 2002).	79(C)(2)(TV), 04 FR 2034	J (Way 12,		
8. 01	The amount of increase if the hospital was awarded FTE cap slo	ats under 8 5502 of the	ACA If the cost	0. 00	8. 01
0.01	report straddles July 1, 2011, see instructions.	ots under 9 5505 of the h	ACA. II the cost	0.00	0.01
8. 02	The amount of increase if the hospital was awarded FTE cap slo	nts from a closed teachin	na hosni tal	0.00	8. 02
0.02	under § 5506 of ACA. (see instructions)	ots from a crosed teaching	ig nospi tai	0.00	0.02
9. 00	Sum of lines 5 plus 6 minus lines (7 and 7.01) plus/minus line	as (8 8 01 and 8 02) (see	0.00	9. 00
7.00	instructions)	es (0, 0,01 and 0,02) (366	0.00	7.00
10. 00	FTE count for allopathic and osteopathic programs in the curre	ent vear from your recor	de	0.00	10.00
11. 00	FTE count for residents in dental and podiatric programs.	sire year from your record			11. 00
12. 00	Current year allowable FTE (see instructions)			0.00	•
13. 00	Total allowable FTE count for the prior year.			0.00	•
14. 00	Total allowable FTE count for the penultimate year if that year	ar anded on or after Son	tombor 20 1007	0.00	ı
14.00	otherwise enter zero.	ai ended on or arter sep	telliber 30, 1997,	0.00	14.00
15. 00	Sum of lines 12 through 14 divided by 3.			0.00	15. 00
16. 00					16. 00
		SUPO			17. 00
	Adjustment for residents displaced by program or hospital clos	Sui e		0.00	1
	Adjusted rolling average FTE count			0.000000	
	Current year resident to bed ratio (line 18 divided by line 4)).		0.000000	
	Prior year resident to bed ratio (see instructions)				
21. 00	Enter the lesser of lines 19 or 20 (see instructions)			0. 000000	
22. 00	IME payment adjustment (see instructions)			0	22. 00
22. 01	IME payment adjustment - Managed Care (see instructions)	C 11 MMA		0	22. 01
00.00	Indirect Medical Education Adjustment for the Add-on for § 422		ED 440 40E	0.00	00.00
23.00	Number of additional allopathic and osteopathic IME FTE reside	ent cap slots under 42 C	FR 412. 105	0. 00	23. 00
04.00	(f)(1)(iv)(C).			0.00	04.00
24. 00	IME FTE Resident Count Over Cap (see instructions)	6.1.	04 (24.00
25. 00	If the amount on line 24 is greater than -0-, then enter the I	lower of line 23 or line	24 (see	0. 00	25. 00
04 00	instructions)			0.000000	0, 00
26. 00	Resident to bed ratio (divide line 25 by line 4)			0. 000000	•
27. 00	IME payments adjustment factor. (see instructions)			0. 000000	1
28. 00	,		0	•	
28. 01			0	•	
29. 00	Total IME payment (sum of lines 22 and 28)			0	29. 00
29. 01	Total IME payment - Managed Care (sum of lines 22.01 and 28.07	1)		0	29. 01
	Di sproporti onate Share Adjustment				
	Percentage of SSI recipient patient days to Medicare Part A pa	atient days (see instruc	tions)	3. 33	1
31. 00	Percentage of Medicaid patient days (see instructions)			26. 24	1
	Sum of lines 30 and 31			29. 57	1
	Allowable disproportionate share percentage (see instructions))		13. 61	1
34.00	Disproportionate share adjustment (see instructions)			503, 202	34.00

_CUL	ATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0010	Peri od: From 07/01/2017 To 06/30/2018	Worksheet E Part A Date/Time Pre 11/26/2018 12	pare
		Title XVIII	Hospi tal	PPS	. 03
		11 11 0 7,1111	Prior to 10/1		
			1. 00	2. 00	
	Uncompensated Care Adjustment		5 077 400 447	. 7	
00	Total uncompensated care amount (see instructions)			6, 766, 695, 164	
01 02	Factor 3 (see instructions) Hospital uncompensated care payment (If line 34 is zero, enter	z zoro on this lino) (s	0. 000142294 ee 850, 562	0. 000136154 921, 313	
02	instructions)	zero on this rine) (s	ee 630, 362	921, 313	35.
03		unt (see instructions)	214, 388	689, 091	35
00	Total uncompensated care (sum of columns 1 and 2 on line 35.03		903, 479		36
	Additional payment for high percentage of ESRD beneficiary dis				١
00	Total Medicare discharges on Worksheet S-3, Part I excluding d	discharges for MS-DRGs	2, 208		40
	652, 682, 683, 684 and 685 (see instructions)		Before 1/1	On/After 1/1	
			1. 00	1. 01	
00	Total ESRD Medicare discharges excluding MS-DRGs 652, 682, 68	33, 684 an 685. (see	0	0	41
	instructions)				
01	Total ESRD Medicare covered and paid discharges excluding MS-D	DRGs 652, 682, 683, 68	4 0	0	41
00	an 685. (see instructions) Divide line 41 by line 40 (if less than 10%, you do not qualif	(v for adjustment)	0.00		42
00	Total Medicare ESRD inpatient days excluding MS-DRGs 652, 682				43
-	instructions)	-, eee, ee an eee. (ee			
00	Ratio of average length of stay to one week (line 43 divided b	by line 41 divided by 7	0. 000000		44
	days)				١
00	Average weekly cost for dialysis treatments (see instructions) Total additional payment (line 45 times line 44 times line 41.		0.00	0. 00	45
00	Subtotal (see instructions)	01)	16, 425, 962		47
00	Hospital specific payments (to be completed by SCH and MDH, sm	mall rural hospitals	0		48
	only. (see instructions)				
				Amount	
00	Total payment for inpatient operating costs (see instructions)			1. 00 16, 425, 962	49
00	Payment for inpatient program capital (from Wkst. L, Pt. I and)	1, 284, 076	
00	Exception payment for inpatient program capital (Wkst. L, Pt.		•	0	1
00	Direct graduate medical education payment (from Wkst. E-4, lin			0	52
00	Nursing and Allied Health Managed Care payment			31, 194	
00	Special add-on payments for new technologies			0	
01 00	Islet isolation add-on payment	1)		0	
00	Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, line 69 Cost of physicians' services in a teaching hospital (see intru			0	
00	Routine service other pass through costs (from Wkst. D, Pt. II	•	through 35).	0	
00	Ancillary service other pass through costs from Wkst. D, Pt. I	V, col. 11 line 200)	G ,	31, 627	58
00	Total (sum of amounts on lines 49 through 58)			17, 772, 859	
00	Primary payer payments			5, 000	
00	Total amount payable for program beneficiaries (line 59 minus	line 60)		17, 767, 859	
00	Deductibles billed to program beneficiaries Coinsurance billed to program beneficiaries			1, 730, 176 20, 536	
00	Allowable bad debts (see instructions)			126, 833	
00	Adjusted reimbursable bad debts (see instructions)			82, 441	
00	Allowable bad debts for dual eligible beneficiaries (see instr	ructions)		29, 951	66
00	Subtotal (line 61 plus line 65 minus lines 62 and 63)			16, 099, 588	1
00	Credits received from manufacturers for replaced devices for a			0	
00	Outlier payments reconciliation (sum of lines 93, 95 and 96).	FOR SCH SEE INSTRUCTIO	ns)	0	
00 50	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) Rural Community Hospital Demonstration Project (§410A Demonstr	ration) adjustment (see	instructions)	0	1
87	Demonstration payment adjustment amount before sequestration	(300		0	1
88	SCH or MDH volume decrease adjustment (contractor use only)			0	
89	Pioneer ACO demonstration payment adjustment amount (see instr	ructions)			70
	HSP bonus payment HVBP adjustment amount (see instructions)			0	
	HSP bonus payment HRR adjustment amount (see instructions)			0	
91	1				
91 92	Bundled Model 1 discount amount (see instructions)			001	
90 91 92 93 94	1			-981 -4, 459	70

Health Financial Systems	ST. JOSEPH HOSPITAL &	HEALTH CENT	ER	In Lie	u of Form CMS-2	2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT		Provi der CO	CN: 15-0010	Peri od: From 07/01/2017 To 06/30/2018	Worksheet E Part A Date/Time Pre 11/26/2018 12	
		Title	XVIII	Hospi tal	PPS	
			FFY	(уууу)	Amount	
				0	1. 00	
70.96 Low volume adjustment for federal fisca	al year (yyyy) (Enter i	n column 0		0	0	70. 96

				10 00/30/2010	11/26/2018 12	: 03 pm
		Title	e XVIII	Hospi tal	PPS	•
			FFY	(уууу)	Amount	
				0	1. 00	
70. 96	Low volume adjustment for federal fiscal year (yyyy) (Enter in	column 0		0	0	70. 96
	the corresponding federal year for the period prior to 10/1)					
70. 97	Low volume adjustment for federal fiscal year (yyyy) (Enter in			0	0	70. 97
	the corresponding federal year for the period ending on or aft	er 10/1)				
70. 98	Low Volume Payment-3				0	70. 98
70. 99	HAC adjustment amount (see instructions)				0	70. 99
71. 00	Amount due provider (line 67 minus lines 68 plus/minus lines 6	9 & 70)			16, 094, 148	71.00
71. 01	Sequestration adjustment (see instructions)				321, 883	71. 01
71. 02	Demonstration payment adjustment amount after sequestration				0	71. 02
72.00	Interim payments				15, 606, 153	72. 00
73.00	Tentative settlement (for contractor use only)				0	73.00
74.00	Balance due provider/program (line 71 minus lines 71.01, 71.02	2, 72, and			166, 112	74.00
	73)					
75.00	Protested amounts (nonallowable cost report items) in accordan	nce with			407, 849	75. 00
	CMS Pub. 15-2, chapter 1, §115.2					
	TO BE COMPLETED BY CONTRACTOR (lines 90 through 96)					
90.00	Operating outlier amount from Wkst. E, Pt. A, line 2 (see inst	ructions)			0	90.00
91.00	Capital outlier from Wkst. L, Pt. I, line 2				0	91.00
92.00	Operating outlier reconciliation adjustment amount (see instru	ıcti ons)			0	92.00
93.00	Capital outlier reconciliation adjustment amount (see instruct	i ons)			0	93. 00
94.00	The rate used to calculate the time value of money (see instru	ıcti ons)			0.00	94.00
95.00	Time value of money for operating expenses (see instructions)	,			0	95.00
96.00		i ons)			0	96.00
			·	Prior to 10/1	On/After 10/1	
				1. 00	2. 00	
	HSP Bonus Payment Amount					
100.00	HSP bonus amount (see instructions)			0	0	100. 00
.00.00	HVBP Adjustment for HSP Bonus Payment			<u> </u>	-	
101 00	HVBP adjustment factor (see instructions)			0. 0000000000	0.000000000	101 00
	HVBP adjustment amount for HSP bonus payment (see instructions	:)		0.000000000		102. 00
102.00	HRR Adjustment for HSP Bonus Payment	,,				102.00
103 00	HRR adjustment factor (see instructions)			0.0000	0.0000	103 00
	HRR adjustment amount for HSP bonus payment (see instructions)			0.0000		104. 00
104.00	Rural Community Hospital Demonstration Project (§410A Demonstr		istment	٧	0	104.00
200.00	Is this the first year of the current 5-year demonstration per					200. 00
200.00	Century Cures Act? Enter "Y" for yes or "N" for no.	roa anaci t	.nc 213t			200.00
	Cost Reimbursement					
201 00	Medicare inpatient service costs (from Wkst. D-1, Pt. II, line	49)				201. 00
	Medicare discharges (see instructions)	, 17)				202. 00
	Case-mix adjustment factor (see instructions)					203. 00
203.00	Computation of Demonstration Target Amount Limitation (N/A in	first year	of the curren	nt 5-vear demonst	ration	203.00
	period)	iiist year	or the curren	it 5-year delilorist	i ati on	
204 00	Medicare target amount					204. 00
	Case-mix adjusted target amount (line 203 times line 204)					205. 00
	Medicare inpatient routine cost cap (line 202 times line 205)					206. 00
200.00	Adjustment to Medicare Part A Inpatient Reimbursement					200.00
207.00	Program reimbursement under the §410A Demonstration (see instr	ructions)				207. 00
	Medicare Part A inpatient service costs (from Wkst. E, Pt. A,					208. 00
	Adjustment to Medicare IPPS payments (see instructions)	11116 37)				209. 00
	Reserved for future use					210. 00
211.00	Total adjustment to Medicare IPPS payments (see instructions)					211. 00
212 00	Comparision of PPS versus Cost Reimbursement	111)				212 00
	Total adjustment to Medicare Part A IPPS payments (from line 2	(11)				212. 00
	Low-volume adjustment (see instructions)					213. 00
218.00	Net Medicare Part A IPPS adjustment (difference between PPS an	na cost reim	nbursement)		 -	218. 00
	(line 212 minus line 213) (see instructions)				l	I

In Lieu of Form CMS-2552-10

Period: Worksheet E
From 07/01/2017 Part A Exhibit 4
To 06/30/2018 Date/Time Prepared:
11/26/2018 12:03 pm Health Financial Systems

LOW VOLUME CALCULATION EXHIBIT 4 Provider CCN: 15-0010

Per						1	0 06/30/2018	11/26/2018 12	
1.00 BBG amounts other than nutiling 0.0 1.00 0.			W/S E Dort A	Amounts (from	_		Hospi tal	PPS	
DOC BRG amounts other than outlier 1.00									
Department Dep			0	 					
1.01 Birk amounts other than outlier 1.01 3.640,398 0 3.640,398 3.640,398 1.01	1.00		1. 00	0	0	0	0	0	1. 00
1.02 DRC uncountris other than outlier	1. 01	DRG amounts other than outlier payments for discharges	1. 01	3, 640, 398	0	3, 640, 398		3, 640, 398	1. 01
Operating payeent for Model 4	1. 02	DRG amounts other than outlier payments for discharges	1. 02	11, 148, 767	0		11, 148, 767	11, 148, 767	1. 02
1,04	1.03	operating payment for Model 4 BPCI occurring prior to	1. 03	О	0	0		0	1. 03
2.00	1. 04	DRG for Federal specific operating payment for Model 4 BPCI occurring on or after	1. 04	0	0		0	0	1. 04
2.01 Outlier payments for	2.00	Outlier payments for	2. 00	230, 116	0	88, 133	141, 982	230, 115	2. 00
3.00 Operating outlier 2.01 O O O O O O O O O	2. 01	Outlier payments for	2. 02	0	0	0	0	0	2. 01
Dayments	3. 00	Operating outlier	2. 01	0	0	0	0	0	3. 00
5.00 Amount from Worksheet E. Part 21.00 0.0000000 0.00000000	4. 00	payments		0	0	0	0	0	4. 00
A. I Ine 21 (see Instructions) 6.00 IME payment adjustment (see 22.00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0				0.00000					
6.00 IME payment adjustment (see 22.00 0 0 0 0 0 0 0 0 0	5. 00	I	21. 00	0.000000	0. 000000	0.000000	0.000000		5. 00
MED payment adjustment for 22.01	6. 00	IME payment adjustment (see	22. 00	0	0	0	0	0	6. 00
Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA	6. 01	IME payment adjustment for	22. 01	0	0	0	0	0	6. 01
1.00 IME payment adjustment factor 27.00 0.0000000 0.0000000 0.0000000 0.0000000 0.0000000 0.00000000				1	1. 100 6 1				
See instructions Second Se	7 00						0.000000		7 00
Instructions Response of the payment adjustment add on 28.01 0 0 0 0 0 0 0 0 0		(see instructions)					0	0	8. 00
Instructions Figure Total IME payment (sum of 29.00 0 0 0 0 0 0 0 0 0	8. 01	instructions)	28. 01	0	0	0	0	0	8. 01
1		instructions)							
Care (Sum of lines 6.01 and 8.01) Disproportionate Share Adjustment Share Adjustment Share Adjustment Share Percentage (See instructions) Share percentage (See instructions) Disproportionate share adjustment (See Instructions) Share percentage		lines 6 and 8)		0	0	0	0		
Disproportionate Share Adjustment 33.00	9.01	care (sum of lines 6.01 and	29. 01	0	O	0	0	0	9. 01
Share percentage (see instructions) 11.00 123,865 379,337 503,202 11.00 123,865 379,337 503,202 11.00 120,000 123,865 379,337 503,202 11.00 12.00			ent						
11. 00 Disproportionate share 34. 00 503, 202 0 123, 865 379, 337 503, 202 11. 00 adjustment (see instructions) 10. 01 10. 000 10. 00 10. 00 10. 00 11. 01 10. 000 11. 01 10. 000 11. 01 10. 000 11. 01 10. 000 11. 01 10. 000 11. 01 10. 000 11.	10. 00	l i	33. 00	0. 1361	0. 1361	0. 1361	0. 1361		10. 00
11.01 Uncompensated care payments 36.00 903,479 0 214,388 689,091 903,479 11.01	11. 00	Di sproporti onate share	34.00	503, 202	0	123, 865	379, 337	503, 202	11. 00
12.00 Total ESRD additional payment (see instructions) 46.00 0 0 0 0 0 0 12.00 13.00 Subtotal (see instructions) 47.00 16,425,962 0 4,066,784 12,359,178 16,425,962 13.00 14.00 Hospital specific payments (completed by SCH and MDH, small rural hospitals only.) (see instructions) 15.00 Total payment for inpatient operating costs (see instructions) 16,425,962 0 4,066,784 12,359,178 16,425,962 15.00 15.00 Payment for inpatient program capital (from Wkst. L, Pt. I, if applicable) 17.00 Special add-on payments for new technologies 17.01 Net organ aquisition cost 17.02 Credits received from manufacturers for replaced 68.00 0 0 0 0 0 0 0 17.00 17.00 Total payment for inpatient program of the payment of the payme	11. 01	Uncompensated care payments				214, 388	689, 091	903, 479	11. 01
13.00 Subtotal (see instructions) 47.00 16,425,962 0 4,066,784 12,359,178 16,425,962 13.00 14.00 15.00	12. 00	Total ESRD additional payment		ο beneticiary ο		0	0	0	12. 00
14. 00 Hospital specific payments (completed by SCH and MDH, small rural hospitals only.) (see instructions) 48. 00 0 0 0 0 0 0 14. 00 15. 00 Total payment for inpatient operating costs (see instructions) 49. 00 16, 425, 962 0 4, 066, 784 12, 359, 178 16, 425, 962 15. 00 16. 00 Payment for inpatient program capital (from Wkst. L, Pt. I, if applicable) 50. 00 1, 284, 076 0 315, 572 968, 504 1, 284, 076 16. 00 17. 00 Special add-on payments for new technologies 54. 00 0 0 0 0 0 0 0 17. 01 17. 02 Credits received from manufacturers for replaced 68. 00 0	13. 00		47. 00	16, 425, 962	o	4, 066, 784	12, 359, 178	16, 425, 962	13. 00
15.00 Total payment for inpatient operating costs (see instructions) 16.00 Payment for inpatient program capital (from Wkst. L, Pt. I, if applicable) 17.00 Special add-on payments for new technologies 17.01 Net organ aquisition cost 17.02 Credits received from manufacturers for replaced 49.00 16, 425, 962 0 4, 066, 784 12, 359, 178 16, 425, 962 15.00 0 315, 572 968, 504 1, 284, 076 16.00 0 315, 572 968, 504 1, 284, 076 16.00 0 0 0 0 0 0 17.00 0 0 17.00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0		Hospital specific payments (completed by SCH and MDH, small rural hospitals only.)		0	0	0	0	0	14. 00
Capital (from Wkst. L, Pt. I, if applicable)	15. 00	Total payment for inpatient operating costs (see	49. 00	16, 425, 962	0	4, 066, 784	12, 359, 178	16, 425, 962	15. 00
17. 00 Special add-on payments for new technologies 54.00 0 0 0 0 0 0 0 0 0	16. 00	capital (from Wkst. L, Pt. I, if applicable)	50. 00	1, 284, 076	0	315, 572	968, 504	1, 284, 076	16. 00
17.02 Credits received from 68.00 0 0 0 0 17.02 manufacturers for replaced		Special add-on payments for new technologies	54. 00	0	0	0	0	0	
		Credits received from manufacturers for replaced		O	0	0	0	0	17. 01 17. 02

Ν

100.00

(transfer amount to Wkst. E,

adjustments to Wkst. E, Pt. A.

Pt. A, line) 100.00 Transfer low volume

Part A Exhibit 5

From 07/01/2017 Date/Time Prepared: 06/30/2018 11/26/2018 12:03 pm Title XVIII Hospi tal Period to Total (cols. 2 Wkst. E, Pt. Amt. from Peri od on Wkst. E, Pt. 10/01 after 10/01 A. line and 3) A) 2.00 3. 00 0 4.00 1.00 1.00 DRG amounts other than outlier payments 1.00 1. 00 DRG amounts other than outlier payments for 1.01 1.01 3, 640, 398 3, 640, 398 3, 640, 398 1.01 discharges occurring prior to October 1 1.02 DRG amounts other than outlier payments for 1.02 11, 148, 767 11, 148, 767 11, 148, 767 1.02 discharges occurring on or after October 1 1.03 DRG for Federal specific operating payment 1.03 0 1.03 C for Model 4 BPCI occurring prior to October DRG for Federal specific operating payment 1.04 1.04 1.04 0 0 for Model 4 BPCI occurring on or after October 1 2.00 Outlier payments for discharges (see 2.00 230, 116 88, 133 141, 982 230, 115 2.00 instructions) 2.01 Outlier payments for discharges for Model 4 2.02 0 0 2.01 0 Operating outlier reconciliation 3 00 2 01 O 0 0 3 00 4.00 Managed care simulated payments 3.00 0 0 4.00 Indirect Medical Education Adjustment 5.00 Amount from Worksheet E, Part A, line 21 21.00 0.000000 0.000000 0.000000 5.00 (see instructions) 6 00 IME payment adjustment (see instructions) 22 00 0 0 0 6 00 IME payment adjustment for managed care (see 0 0 6.01 22.01 0 6.01 instructions) Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA 7.00 0.000000 0.000000 7.00 IME payment adjustment factor (see 27.00 0.000000 instructions) 8.00 IME adjustment (see instructions) 28.00 0 8.00 IME payment adjustment add on for managed 0 8.01 28.01 0 8.01 care (see instructions) Total IME payment (sum of lines 6 and 8) 9.00 29.00 0 0 0 9.00 9.01 Total IME payment for managed care (sum of 29.01 C 9.01 lines 6.01 and 8.01) Disproportionate Share Adjustment 10.00 Allowable disproportionate share percentage 33.00 0. 1361 0. 1361 0.1361 10.00 (see instructions) 11.00 Disproportionate share adjustment (see 34.00 503, 202 123, 865 379, 337 503, 202 11.00 instructions) 11.01 Uncompensated care payments 36.00 903, 479 214, 388 689, 091 903, 479 11.01 Additional payment for high percentage of ESRD beneficiary discharges 12 00 Total ESRD additional payment (see 0 12 00 46 00 0 instructions) 13.00 Subtotal (see instructions) 47.00 16, 425, 962 4, 066, 784 12, 359, 178 16, 425, 962 13.00 14.00 Hospital specific payments (completed by SCH 48.00 14.00 and MDH, small rural hospitals only.) (see instructions) Total payment for inpatient operating costs 15.00 49.00 16, 425, 962 4, 066, 784 12, 359, 178 16, 425, 962 15.00 (see instructions) 16.00 Payment for inpatient program capital (from 50.00 1, 284, 076 315, 572 968, 504 1, 284, 076 16.00 Wkst. L, Pt. I, if applicable) 17.00 Special add-on payments for new technologies 54.00 0 17.00 0 17.01 Net organ acquisition cost 17.01 17.02 Credits received from manufacturers for 68.00 0 0 17.02 replaced devices for applicable MS-DRGs 18.00 Capital outlier reconciliation adjustment 93.00 18.00 amount (see instructions)

Provider CCN: 15-0010

Peri od:

4, 382, 356

13, 327, 682

17, 710, 038 19. 00

19.00 SUBTOTAL

Health Financial Systems ST. JOSEPH HOSPITAL & HEALTH CENTER In Lieu of Form CMS-2552-10 HOSPITAL ACQUIRED CONDITION (HAC) REDUCTION CALCULATION EXHIBIT 5 Provider CCN: 15-0010 Peri od: Worksheet E From 07/01/2017 Part A Exhibit 5 06/30/2018 Date/Time Prepared: 11/26/2018 12:03 pm Title XVIII Hospi tal PPS Wkst. L, line (Amt. from L) Wkst. 2.00 3. 00 4.00 n 1 00 20.00 Capital DRG other than outlier 1.00 1, 197, 217 292, 731 904, 486 1, 197, 217 20.00 20.01 Model 4 BPCI Capital DRG other than outlier 1.01 20.01 12, 991 21.00 Capital DRG outlier payments 2.00 4,779 8, 212 12, 991 21.00 21.01 Model 4 BPCI Capital DRG outlier payments 2.01 21.01 0 22.00 Indirect medical education percentage (see 5.00 0.0000 0.0000 0.0000 22.00 instructions) 23.00 Indirect medical education adjustment (see 6.00 0 23.00 instructions) 0.0617 24 00 Allowable disproportionate share percentage 10 00 0.0617 0.0617 24 00 (see instructions) 25.00 Disproportionate share adjustment (see 11.00 73, 868 18,062 55, 806 73,868 25.00 instructions) Total prospective capital payments (see 12.00 1, 284, 076 315, 572 968, 504 1, 284, 076 26.00 instructions) Wkst. E. Pt. (Amt. from A, line Wkst. E, Pt. A) 0 1.00 2.00 3.00 4.00 27. 00 27. 00 28.00 Low volume adjustment prior to October 1 70.96 0 28.00 Ω 29.00 Low volume adjustment on or after October 1 70.97 0 29.00 HVBP payment adjustment (see instructions) 70. 93 -981 -12, 055 11, 074 -981 30.00 30.00 HVBP payment adjustment for HSP bonus 30.01 70.90 30.01 0 payment (see instructions) 31.00 HRR adjustment (see instructions) 70.94 -4, 459 0 -4, 459 -4, 459 31.00 31.01 HRR adjustment for HSP bonus payment (see 70. 91 0 31.01 instructions) (Amt. to Wkst. Pt. A) Ε, 0 1.00 2.00 3.00 4.00 32.00 HAC Reduction Program adjustment (see 70.99 0 0 32.00 instructions) 100.00 Transfer HAC Reduction Program adjustment to Ν 100.00

Wkst. E, Pt. A.

Health Financial Systems	ST. JOSEPH HOSPITAL &	HEALTH CENTER	In Lie	u of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 15-0010	Peri od: From 07/01/2017 To 06/30/2018	Worksheet E Part B Date/Time Prepared: 11/26/2018 12:03 pm

			10 00/30/2016	11/26/2018 12	
		Title XVIII	Hospi tal	PPS	
				1. 00	
4 00	PART B - MEDICAL AND OTHER HEALTH SERVICES			0.707	4 00
1. 00 2. 00	Medical and other services (see instructions)	ti ons)		2, 797	1. 00 2. 00
3.00	Medical and other services reimbursed under OPPS (see instruction OPPS payments	tions)		20, 419, 255 18, 650, 216	3.00
4. 00	Outlier payment (see instructions)			155, 552	4.00
4. 01	Outlier reconciliation amount (see instructions)			155, 552	4. 01
5. 00	Enter the hospital specific payment to cost ratio (see instru	ctions)		0. 000	5.00
6.00	Line 2 times line 5			0	6.00
7.00	Sum of lines 3, 4, and 4.01, divided by line 6			0.00	7. 00
8.00	Transitional corridor payment (see instructions)			0	8. 00
9.00	Ancillary service other pass through costs from Wkst. D, Pt.	IV, col. 13, line 200		194, 681	
10.00	Organ acquisitions			0	10.00
11. 00	Total cost (sum of lines 1 and 10) (see instructions)			2, 797	11. 00
	COMPUTATION OF LESSER OF COST OR CHARGES				-
12. 00	Reasonable charges Ancillary service charges			6, 474	12. 00
13. 00	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, I	ine 69)		0, 474	1
14. 00	Total reasonable charges (sum of lines 12 and 13)	1116 07)		6, 474	
00	Customary charges			0, 1, 1	
15.00	Aggregate amount actually collected from patients liable for	payment for services on a	a charge basis	0	15. 00
16.00	Amounts that would have been realized from patients liable for	r payment for services or	n a chargebasis	0	16. 00
	had such payment been made in accordance with 42 CFR §413.13(e)			
17. 00	Ratio of line 15 to line 16 (not to exceed 1.000000)			0. 000000	
18.00	Total customary charges (see instructions)		443. (6, 474	
19. 00	Excess of customary charges over reasonable cost (complete on	ly it line 18 exceeds lir	ne II) (see	3, 677	19. 00
20. 00	<pre>instructions) Excess of reasonable cost over customary charges (complete on</pre>	lv if line 11 evceeds lin	na 18) (saa	0	20. 00
20.00	instructions)	Ty IT Title IT exceeds ITT	10) (366	O	20.00
21.00	Lesser of cost or charges (see instructions)			2, 797	21.00
22.00	Interns and residents (see instructions)			0	22. 00
23. 00	Cost of physicians' services in a teaching hospital (see inst	ructions)		0	23. 00
24.00	Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9)			19, 000, 449	24.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT			_	
25. 00	Deductibles and coinsurance (for CAH, see instructions)	- CALL !+!)		0	25. 00
26. 00 27. 00	Deductibles and Coinsurance relating to amount on line 24 (for		and 221 (coo	3, 547, 280	
27.00	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) instructions)	prus the sum of filles 22	and 23] (See	15, 455, 966	27.00
28. 00	Direct graduate medical education payments (from Wkst. E-4, I	ine 50)		0	28. 00
29. 00	ESRD direct medical education costs (from Wkst. E-4, line 36)	,		0	
30.00	Subtotal (sum of lines 27 through 29)			15, 455, 966	30.00
31. 00	Primary payer payments			1, 588	31. 00
32. 00	Subtotal (line 30 minus line 31)			15, 454, 378	32.00
	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICE	CES)			
33. 00	Composite rate ESRD (from Wkst. I-5, line 11)			240 505	33.00
34. 00 35. 00	Allowable bad debts (see instructions) Adjusted reimbursable bad debts (see instructions)			369, 595 240, 237	
36. 00	Allowable bad debts for dual eligible beneficiaries (see inst	ructions)		161, 335	
37. 00		r de trons)		15, 694, 615	
38. 00	MSP-LCC reconciliation amount from PS&R			0	
39. 00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	
39. 50	Pioneer ACO demonstration payment adjustment (see instructions	s)			39. 50
39. 97	Demonstration payment adjustment amount before sequestration			0	39. 97
39. 98	Partial or full credits received from manufacturers for repla	ced devices (see instruct	tions)	0	39. 98
39. 99	RECOVERY OF ACCELERATED DEPRECIATION			0	39. 99
40. 00	Subtotal (see instructions)			15, 694, 615	
40. 01	Sequestration adjustment (see instructions)			313, 892	
40. 02	Demonstration payment adjustment amount after sequestration			0 15, 363, 576	
41. 00 42. 00					41. 00 42. 00
42.00				0 17, 147	
44. 00	,			17, 147	
00	§115. 2		p: 11		55
	TO BE COMPLETED BY CONTRACTOR]
90.00	Original outlier amount (see instructions)			0	
91. 00	Outlier reconciliation adjustment amount (see instructions)			0	
92. 00	The rate used to calculate the Time Value of Money			0.00	
93. 00	Time Value of Money (see instructions)			0	
94.00	Total (sum of lines 91 and 93)			0	94.00

In Lieu of Form CMS-2552-10

| Period: | Worksheet E-1 |
| From 07/01/2017 | Part |
| To 06/30/2018 | Date/Time Prepared: | 11/26/2018 | 12:03 pm Health Financial Systems ST. JOSEP ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED Provider CCN: 15-0010

			'		11/26/2018 12:	
		Title	XVIII	Hospi tal	PPS	
		I npati en	t Part A	Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3. 00	4.00	
1. 00	Total interim payments paid to provider		15, 606, 153	3	15, 363, 576	1. 00
2.00	Interim payments payable on individual bills, either				0	2.00
	submitted or to be submitted to the contractor for					
	services rendered in the cost reporting period. If none,					
	write "NONE" or enter a zero					
3.00	List separately each retroactive lump sum adjustment					3. 00
	amount based on subsequent revision of the interim rate					
	for the cost reporting period. Also show date of each					
	payment. If none, write "NONE" or enter a zero. (1)					
3. 01	Program to Provider ADJUSTMENTS TO PROVIDER				0	3. 01
3. 01	ADJUSTIMENTS TO PROVIDER					3. 01
3. 02						3. 02
3. 04						3. 04
3. 05						3. 05
3.03	Provider to Program			′ I		3. 03
3.50	ADJUSTMENTS TO PROGRAM		(0	3. 50
3. 51			d		0	3. 51
3.52					0	3. 52
3.53					0	3. 53
3.54			(0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines		C		0	3. 99
	3. 50-3. 98)					
4.00	Total interim payments (sum of lines 1, 2, and 3.99)		15, 606, 153	3	15, 363, 576	4. 00
	(transfer to Wkst. E or Wkst. E-3, line and column as					
	appropri ate)					
F 00	TO BE COMPLETED BY CONTRACTOR					F 00
5. 00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none,					5. 00
	write "NONE" or enter a zero. (1)					
	Program to Provider		l			
5. 01	TENTATI VE TO PROVI DER		C		0	5. 01
5. 02			d		l ol	5. 02
5.03			ď		0	5. 03
	Provider to Program					
5.50	TENTATI VE TO PROGRAM		C)	0	5.50
5. 51			C		0	5. 51
5. 52			()	0	5. 52
5. 99	Subtotal (sum of lines 5.01-5.49 minus sum of lines		()	0	5. 99
	5. 50-5. 98)					
6. 00	Determined net settlement amount (balance due) based on					6. 00
4 01	the cost report. (1)		1// 110		17 147	4 01
6. 01 6. 02	SETTLEMENT TO PROVIDER SETTLEMENT TO PROGRAM		166, 112		17, 147	6. 01 6. 02
6. 02 7. 00	Total Medicare program liability (see instructions)		15, 772, 265		15, 380, 723	6. 02 7. 00
7.00	Total medicale program frability (see firstructions)		10, 112, 200	Contractor	NPR Date	7.00
				Number	(Mo/Day/Yr)	
		()	1. 00	2.00	
8. 00	Name of Contractor					8. 00
	'			•	. '	

| In Lieu of Form CMS-2552-10 | Period: | Worksheet E-1 | From 07/01/2017 | Part | Date/Time Prepared: 11/26/2018 12:03 pm | PDS Component CCN: 15-T010

		Title	XVIII	Subprovider - IRF	PPS	
		Inpatien	t Part A	Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2. 00	3. 00	4. 00	
1.00	Total interim payments paid to provider		3, 980, 80	7	0	1. 00
2.00	Interim payments payable on individual bills, either			0	0	2. 00
	submitted or to be submitted to the contractor for					
	services rendered in the cost reporting period. If none,					
3.00	write "NONE" or enter a zero List separately each retroactive lump sum adjustment					3. 00
3.00	amount based on subsequent revision of the interim rate					3.00
	for the cost reporting period. Also show date of each					
	payment. If none, write "NONE" or enter a zero. (1)					
	Program to Provider					
3. 01	ADJUSTMENTS TO PROVIDER			0	0	3. 01
3. 02				0	0	3. 02
3. 03 3. 04				0	0	3. 03 3. 04
3.04				0		3. 04
3.03	Provider to Program			0	0	3.03
3.50	ADJUSTMENTS TO PROGRAM			0	0	3. 50
3.51				0	0	3. 51
3.52			(0	0	3. 52
3.53				0	0	3. 53
3.54				0	0	3. 54
3. 99	Subtotal (sum of lines 3.01-3.49 minus sum of lines		'	0	0	3. 99
4. 00	3.50-3.98) Total interim payments (sum of lines 1, 2, and 3.99)		3, 980, 80	7	0	4. 00
4.00	(transfer to Wkst. E or Wkst. E-3, line and column as		3, 700, 00	'	U	4.00
	appropri ate)					
	TO BE COMPLETED BY CONTRACTOR					
5.00	List separately each tentative settlement payment after					5. 00
	desk review. Also show date of each payment. If none,					
	write "NONE" or enter a zero. (1) Program to Provider					
5. 01	TENTATI VE TO PROVI DER			0	0	5. 01
5. 02	TENTATI VE TO TROVIDER			0		5. 02
5. 03				Ö	Ö	5. 03
	Provider to Program					
5.50	TENTATI VE TO PROGRAM			0	0	5. 50
5. 51				0	0	5. 51
5. 52				0	0	5. 52
5. 99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		'	0	0	5. 99
6. 00	Determined net settlement amount (balance due) based on					6. 00
0.00	the cost report. (1)					0.00
6. 01	SETTLEMENT TO PROVI DER		2, 19	6	0	6. 01
6.02	SETTLEMENT TO PROGRAM			0	0	6. 02
7. 00	Total Medicare program liability (see instructions)		3, 983, 00		0	7. 00
				Contractor	NPR Date	
		()	Number 1.00	(Mo/Day/Yr) 2.00	
8. 00	Name of Contractor	()	1.00	2.00	8. 00
5. 00	name of contractor			I	1	0.00

Heal th	Financial Systems ST. JOSEPH HOSPITAL 8	& HEALTH CENTER	In Lie	u of Form CMS-	-2552-10
CALCUL	CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT Provider CCN: 15-0010 Period: Wo				
			To 06/30/2018		
		Title XVIII	Hospi tal	PPS	2.00 piii
	<u> </u>				
				1.00	
	TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS				
	HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION				
1. 00	Total hospital discharges as defined in AARA §4102 from Wkst.		14		1. 00
2.00	Medicare days from Wkst. S-3, Pt. I, col. 6 sum of lines 1, 8	3-12			2. 00
3.00	Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2				3. 00
4.00	Total inpatient days from S-3, Pt. I col. 8 sum of lines 1, 8	3-12			4. 00
5.00	Total hospital charges from Wkst C, Pt. I, col. 8 line 200				5. 00
6.00	Total hospital charity care charges from Wkst. S-10, col. 3 l				6. 00 7. 00
7.00					
	line 168				
8.00	Calculation of the HIT incentive payment (see instructions)				8. 00
9.00	Sequestration adjustment amount (see instructions)				9. 00
10.00	Calculation of the HIT incentive payment after sequestration	(see instructions)			10. 00
	INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH				
30.00	Initial/interim HIT payment adjustment (see instructions)				30.00
31.00	Other Adjustment (specify)				31.00
32. 00	Balance due provider (line 8 (or line 10) minus line 30 and l	ine 31) (see instruction	s)		32. 00

Health Financial Systems	ST. JOSEPH HOSPITAL &	HEALTH CENTER	In Lie	u of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 15-0010		Worksheet E-3
			From 07/01/2017	
		Component CCN: 15-T010	To 06/30/2018	Date/Time Prepared:
				11/26/2018 12:03 pm
		Title XVIII	Subprovi der -	PPS
			LDE	

		litle XVIII	Subprovider -	PPS	
	PART III - MEDICARE PART A SERVICES - IRF PPS			1. 00	
1.00	Net Federal PPS Payment (see instructions)		I	3, 963, 754	1.00
2.00	Medicare SSI ratio (IRF PPS only) (see instructions)			0. 0382	2.00
3.00	Inpatient Rehabilitation LIP Payments (see instructions)			88, 788	
4.00	Outlier Payments			53, 919	
5.00	Unweighted intern and resident FTE count in the most recent co	ost reporting period en	ding on or prior	0.00	
0.00	to November 15, 2004 (see instructions)	sat reporting partial an	arrig or or privar	0.00	0.00
5. 01	Cap increases for the unweighted intern and resident FTE count	for residents that wer	e displaced by	0. 00	5. 01
	program or hospital closure, that would not be counted without				
	CFR §412. 424(d)(1)(iii)(F)(1) or (2) (see instructions)	. 3 . 3			
6.00	New Teaching program adjustment. (see instructions)			0. 00	6. 00
7.00	Current year's unweighted FTE count of I&R excluding FTEs in	the new program growth p	eriod of a "new	0. 00	7. 00
	teaching program" (see instructions)				
8.00	Current year's unweighted I&R FTE count for residents within	the new program growth p	eriod of a "new	0. 00	8. 00
	teaching program" (see instructions)				
9.00	Intern and resident count for IRF PPS medical education adjust	tment (see instructions)		0. 00	
10.00	Average Daily Census (see instructions)			9. 717808	1
11. 00	Teaching Adjustment Factor (see instructions)			0. 000000	1
12.00	Teaching Adjustment (see instructions)			0	12.00
13.00	Total PPS Payment (see instructions)			4, 106, 461	13.00
14.00	Nursing and Allied Health Managed Care payments (see instructi	on)		0	
15.00	Organ acquisition (DO NOT USE THIS LINE)				15.00
16.00	Cost of physicians' services in a teaching hospital (see insti	ructions)		0	
17. 00	Subtotal (see instructions)			4, 106, 461	
18.00	Primary payer payments			0	
19. 00 20. 00	Subtotal (line 17 less line 18).			4, 106, 461	
21. 00	Deductibles Subtotal (line 19 minus line 20)			45, 104 4, 061, 357	1
21.00	Coi nsurance			4, 001, 357	1
23. 00	Subtotal (line 21 minus line 22)			4, 061, 357	
24. 00	Allowable bad debts (exclude bad debts for professional service	cas) (saa instructions)		2, 928	ı
25. 00	Adjusted reimbursable bad debts (see instructions)	ces) (see mistructions)		1, 903	
26. 00	Allowable bad debts for dual eligible beneficiaries (see insti	cuctions)		2, 667	
27. 00	Subtotal (sum of lines 23 and 25)	uctions)		4, 063, 260	1
28. 00	Direct graduate medical education payments (from Wkst. E-4, Li	ne 49)		4, 003, 200	28.00
29. 00	Other pass through costs (see instructions)	110 17)		1, 029	
30.00	Outlier payments reconciliation			0	•
31. 00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	
31. 50	Pioneer ACO demonstration payment adjustment (see instructions	5)		0	31. 50
31. 99	Demonstration payment adjustment amount before sequestration	-,		0	31. 99
32. 00	Total amount payable to the provider (see instructions)			4, 064, 289	32.00
32. 01	Seguestration adjustment (see instructions)			81, 286	
32. 02	Demonstration payment adjustment amount after sequestration			0	32. 02
33.00	Interim payments			3, 980, 807	33.00
34.00	Tentative settlement (for contractor use only)			0	34.00
35.00	Balance due provider/program (line 32 minus lines 32.01, 32.02	2, 33, and 34)	İ	2, 196	35.00
36.00	Protested amounts (nonallowable cost report items) in accordan	nce with CMS Pub. 15-2,	chapter 1,	49, 942	36. 00
	§115. 2				
	TO BE COMPLETED BY CONTRACTOR				
50.00	Original outlier amount from Wkst. E-3, Pt. III, line 4			53, 919	50.00
51.00	Outlier reconciliation adjustment amount (see instructions)			0	
52.00	The rate used to calculate the Time Value of Money			0.00	
53.00	Time Value of Money (see instructions)			0	53. 00
			·	·	

Health Financial Systems	ST. JOSEPH HOSPITAL &	HEALTH CENTER	In Lie	u of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 15-0010	Peri od: From 07/01/2017 To 06/30/2018	Worksheet E-3 Part VII Date/Time Prepared: 11/26/2018 12:03 pm

			To 06/30/2018	Date/Time Pre 11/26/2018 12	
		Title XIX	Hospi tal	Cost	<u> </u>
		<u> </u>	Inpati ent	Outpati ent	
			1. 00	2.00	
	PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERV	VICES FOR TITLES V OR XIX	X SERVICES		
	COMPUTATION OF NET COST OF COVERED SERVICES				
1.00	Inpatient hospital/SNF/NF services		4, 365, 126		1. 00
2.00	Medical and other services			10, 030, 697	2. 00
3.00	Organ acquisition (certified transplant centers only)		0		3. 00
4.00	Subtotal (sum of lines 1, 2 and 3)		4, 365, 126	10, 030, 697	4. 00
5.00	Inpatient primary payer payments		0		5. 00
6.00	Outpati ent pri mary payer payments			0	6. 00
7. 00	Subtotal (line 4 less sum of lines 5 and 6)		4, 365, 126	10, 030, 697	7. 00
	COMPUTATION OF LESSER OF COST OR CHARGES				
8. 00	Reasonable Charges Routine service charges		7, 631, 770		8. 00
9. 00	Ancillary service charges		18, 033, 644	52, 678, 107	9. 00
10. 00	Organ acquisition charges, net of revenue		18, 033, 044	32, 070, 107	10.00
11. 00	Incentive from target amount computation		o o		11. 00
12. 00	Total reasonable charges (sum of lines 8 through 11)		25, 665, 414	52, 678, 107	1
12.00	CUSTOMARY CHARGES		20,000,111	02/0/0/10/	12.00
13.00	Amount actually collected from patients liable for payment for	services on a charge	0	0	13. 00
	basis	_			
14.00	Amounts that would have been realized from patients liable for		0	0	14. 00
	a charge basis had such payment been made in accordance with 4	2 CFR §413.13(e)			
15. 00	Ratio of line 13 to line 14 (not to exceed 1.000000)		0.000000	0.000000	1
16.00	Total customary charges (see instructions)	v if line 1/ evenede	25, 665, 414	52, 678, 107	16.00
17. 00	Excess of customary charges over reasonable cost (complete only line 4) (see instructions)	y if line 16 exceeds	21, 300, 288	42, 647, 410	17. 00
18. 00	Excess of reasonable cost over customary charges (complete only	v if line 4 exceeds line	0	0	18. 00
10.00	16) (see instructions)	y II IIIIe I exceeds IIIIe		Ü	10.00
19. 00	Interns and Residents (see instructions)		o	0	19. 00
20.00	Cost of physicians' services in a teaching hospital (see instri	uctions)	o	0	20. 00
21.00	Cost of covered services (enter the lesser of line 4 or line 1		4, 365, 126	10, 030, 697	21. 00
	PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be	completed for PPS provide			
	Other than outlier payments		0	0	
23. 00	Outlier payments		0	0	23. 00
24. 00	Program capital payments		0		24. 00
25. 00	Capital exception payments (see instructions) Routine and Ancillary service other pass through costs		0	0	25. 00 26. 00
26.00	Subtotal (sum of lines 22 through 26)		0	0	26.00
28. 00	Customary charges (title V or XIX PPS covered services only)			0	28.00
29. 00	, , , , , , , , , , , , , , , , , , , ,		4, 365, 126	10, 030, 697	
27.00	COMPUTATION OF REIMBURSEMENT SETTLEMENT		1,000,120	10,000,077	27.00
30.00	Excess of reasonable cost (from line 18)		0	0	30.00
31.00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)		4, 365, 126	10, 030, 697	31.00
32.00	Deducti bl es		0	0	32. 00
33.00			0	0	
34. 00	· · · · · · · · · · · · · · · · · · ·		0	0	34. 00
35. 00	Utilization review		0		35. 00
36.00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and	33)	4, 365, 126	10, 030, 697	1
	O OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		4, 365, 126	0 10, 030, 697	37. 00 38. 00
	00 Subtotal (line 36 ± line 37)		4, 305, 120	10, 030, 697	39.00
40. 00	00 Direct graduate medical education payments (from Wkst. E-4) 00 Total amount payable to the provider (sum of lines 38 and 39)		4, 365, 126	10, 030, 697	
41. 00	Interim payments		4, 365, 126	10, 030, 697	
42. 00	Balance due provider/program (line 40 minus line 41)		4, 303, 120	10, 030, 077	1
43. 00	Protested amounts (nonallowable cost report items) in accordance	ce with CMS Pub 15-2.	o	0	1
	chapter 1, §115.2	·			

Health Financial Systems	ST. JOSEPH HOSPITAL &	HEALTH CENTER	In Lie	u of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 15-0010	Period: From 07/01/2017	Worksheet E-3 Part VII
		Component CCN: 15-T010		Date/Time Prepared: 11/26/2018 12:03 pm
		Title XIX	Subprovi der -	Cost

		II tie xix	I RF	COST	
			Inpati ent	Outpati ent	
			1. 00	2. 00	
	PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVICE	S FOR TITLES V OR XIX		2.00	
	COMPUTATION OF NET COST OF COVERED SERVICES	TOR TITLES V OR ALL	OERVI OEO		
1.00	Inpatient hospital/SNF/NF services		32, 220		1.00
2. 00	Medical and other services		02, 220	0	
3.00	Organ acquisition (certified transplant centers only)		0	· ·	3.00
4.00	Subtotal (sum of lines 1, 2 and 3)		32, 220	0	4. 00
5. 00	Inpatient primary payer payments		02,220	Ü	5. 00
6.00	Outpatient primary payer payments			0	6.00
7. 00	Subtotal (line 4 less sum of lines 5 and 6)		32, 220	0	
7.00	COMPUTATION OF LESSER OF COST OR CHARGES		02/220		,
	Reasonable Charges				
8.00	Routi ne servi ce charges		133, 671		8.00
9. 00	Ancillary service charges		68, 785	0	
10.00	Organ acquisition charges, net of revenue		0	Ü	10.00
11. 00	Incentive from target amount computation		o		11.00
12. 00	Total reasonable charges (sum of lines 8 through 11)		202, 456	0	1
.2.00	CUSTOMARY CHARGES		2027 100		12.00
13.00	Amount actually collected from patients liable for payment for ser	rvices on a charge	O	0	13. 00
	basis	r. coc c a ca. ge		Ü	10.00
14.00	Amounts that would have been realized from patients liable for pay	ment for services on	0	0	14.00
	a charge basis had such payment been made in accordance with 42 CF				
15.00	Ratio of line 13 to line 14 (not to exceed 1.000000)	. ,	0.000000	0.000000	15. 00
16.00	Total customary charges (see instructions)		202, 456	0	16. 00
17.00	Excess of customary charges over reasonable cost (complete only if	fline 16 exceeds	170, 236	0	17. 00
	line 4) (see instructions)				
18.00	Excess of reasonable cost over customary charges (complete only if	fline 4 exceeds line	0	0	18. 00
	16) (see instructions)				
19.00	Interns and Residents (see instructions)		0	0	19. 00
20.00	Cost of physicians' services in a teaching hospital (see instructi	ons)	0	0	20. 00
21.00	Cost of covered services (enter the lesser of line 4 or line 16)		32, 220	0	21. 00
	PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be comp	oleted for PPS provide	rs.		
22. 00	Other than outlier payments		0	0	22. 00
23. 00	Outlier payments		0	0	23. 00
	Program capital payments		0		24. 00
	Capital exception payments (see instructions)		0		25. 00
	Routine and Ancillary service other pass through costs		0	0	
27. 00	Subtotal (sum of lines 22 through 26)		0	0	
28. 00	Customary charges (title V or XIX PPS covered services only)		0	0	l
29. 00	Titles V or XIX (sum of lines 21 and 27)		32, 220	0	29. 00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT				
	Excess of reasonable cost (from line 18)		0	0	
31. 00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)		32, 220	0	31. 00
32.00	Deducti bl es		0	0	
33. 00	Coi nsurance		0	0	
	Allowable bad debts (see instructions)		0	0	34. 00
35. 00	Utilization review		0		35. 00
36. 00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33))	32, 220	0	
	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	0	
	Subtotal (line 36 ± line 37)		32, 220	0	38. 00
	Direct graduate medical education payments (from Wkst. E-4)		0	_	39. 00
40.00	Total amount payable to the provider (sum of lines 38 and 39)		32, 220	0	40.00
	Interim payments		32, 220	0	41.00
42.00	Balance due provider/program (line 40 minus line 41)		0	0	42.00
43. 00	Protested amounts (nonallowable cost report items) in accordance w	WITH CMS Pub 15-2,	0	0	43. 00
	chapter 1, §115.2		1		I

Health Financial Systems ST. JOSEPH HOSPI
BALANCE SHEET (If you are nonproprietary and do not maintain
fund-type accounting records, complete the General Fund column onl y)

Provider CCN: 15-0010

In Lieu of Form CMS-2552-10

oni y)			'	00/00/2010	11/26/2018 12	2: 03 pm
		General Fund	Specific Purpose Fund	Endowment Fund		
		1.00	2. 00	3. 00	4. 00	
	CURRENT ASSETS	T	.1	.T		
1.00	Cash on hand in banks	1, 275		0	0	
2. 00 3. 00	Temporary investments				0	
4.00	Notes recei vabl e Accounts recei vabl e	46, 012, 159	1	1	0	
5.00	Other receivable	1, 017, 471			0	
6. 00	Allowances for uncollectible notes and accounts receivable	-25, 499, 214		0	0	
7. 00	Inventory	1, 949, 709			0	
8. 00	Prepaid expenses	118, 643		0	Ö	
9.00	Other current assets	3, 210, 264		0	0	9. 00
10.00	Due from other funds	722, 779) (0	0	10.00
11.00	Total current assets (sum of lines 1-10)	27, 533, 086		0	0	11. 00
	FIXED ASSETS					
12.00	Land	1, 764, 978	1			1
13. 00	Land improvements	0)	-	0	
14. 00	Accumulated depreciation	-1, 466, 917	1			1
15. 00	Bui I di ngs	63, 507, 337	1	-	0	
16. 00	Accumulated depreciation	-53, 597, 860	1	-	0	1
17. 00	Leasehold improvements	528, 071		-	0	
18.00	Accumulated depreciation	-528, 071		-	0	
19.00	Fixed equipment	24, 373, 785	1	0	0	
20.00	Accumulated depreciation	-20, 658, 048	1	0	0	
21. 00	Automobiles and trucks			-	0 0	
22. 00	Accumulated depreciation	40, 646, 037) (-	0	
23. 00 24. 00	Major movable equipment Accumulated depreciation	-34, 603, 969	1	-		
25. 00	Minor equipment depreciable	603, 752	•	-		
26. 00	Accumulated depreciation	-522, 480		-		
27. 00	HIT desi gnated Assets	-522, 460			0	
28. 00	Accumulated depreciation	9, 757	,		0	
29. 00	Mi nor equi pment-nondepreci abl e	4, 584, 090		1	0	
30.00	Total fixed assets (sum of lines 12-29)	24, 640, 462	1			
00.00	OTHER ASSETS	21,010,102		<u> </u>		00.00
31. 00	Investments	107, 769) (0	0	31.00
32. 00	Deposits on Leases	0			Ö	
33. 00	Due from owners/officers			0	0	
34.00	Other assets			0	0	34.00
35.00	Total other assets (sum of lines 31-34)	107, 769		0	0	35. 00
36.00	Total assets (sum of lines 11, 30, and 35)	52, 281, 317	(0	0	36. 00
	CURRENT LIABILITIES					
37.00	Accounts payable	7, 617, 362	2	0	0	37. 00
38. 00	Salaries, wages, and fees payable	1, 115, 471		0	0	38. 00
39. 00	Payroll taxes payable	2, 269, 274	. (0	0	•
40.00	Notes and Loans payable (short term)	220, 652	! (0	0	
41. 00	Deferred income	0)	0	0	
42. 00	Accel erated payments	0)			42. 00
43. 00	Due to other funds	12, 299, 855	1	0	0	
44.00	Other current liabilities	1, 913, 584	1	-	-	
45. 00	Total current liabilities (sum of lines 37 thru 44)	25, 436, 198	3 (0	0	45. 00
47.00	LONG TERM LIABILITIES	1				4,, 00
46. 00	Mortgage payable	15 400 404		٥ -	0	
47. 00	Notes payable	15, 482, 494	1	0		1
48. 00	Unsecured Loans	1 027 007			-	
49. 00 50. 00	Other long term liabilities Total long term liabilities (sum of lines 46 thru 49)	1, 937, 907	1	-	0	1
51. 00	Total liabilities (sum of lines 45 and 50)	17, 420, 401 42, 856, 599				
	CAPI TAL ACCOUNTS			<u>J</u>	0	
52. 00	General fund balance	9, 424, 718				52. 00
53. 00	Specific purpose fund			ון		53. 00
54.00	Donor created - endowment fund balance - restricted			0		54. 00
55. 00	Donor created - endowment fund balance - unrestricted			0		55. 00
56.00	Governing body created - endowment fund balance			0	_	56. 00
57. 00	Plant fund balance - invested in plant				0	•
58. 00	Plant fund balance - reserve for plant improvement,				0	58. 00
E0 00	replacement, and expansion	0 404 710	,	_	_	E0 00
59. 00 60. 00	Total fund balances (sum of lines 52 thru 58) Total liabilities and fund balances (sum of lines 51 and	9, 424, 718 52, 281, 317			0	
50.00	[59]	32,201,317		1		00.00
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Health Financial Systems
STATEMENT OF CHANGES IN FUND BALANCES Provider CCN: 15-0010

					То	06/30/2018	Date/Time Prep 11/26/2018 12	
		General	Fund	Speci al	Pur	pose Fund	Endowment Fund	о ріп
		1.00	2.00	3. 00		4. 00	5. 00	
1.00	Fund balances at beginning of period		5, 273, 081			0		1. 00
2.00	Net income (loss) (from Wkst. G-3, line 29)		19, 357, 596			_		2. 00
3.00	Total (sum of line 1 and line 2)	175 0/0	24, 630, 677			0		3. 00
4. 00 5. 00	RESTRICTED ACTIVITY	175, 068			0		0	4. 00 5. 00
6. 00					0			6. 00
7. 00					0		Ö	7. 00
8.00		l o			0		Ö	8. 00
9.00		o			0		0	9. 00
10.00	Total additions (sum of line 4-9)		175, 068			0		10.00
11. 00	Subtotal (line 3 plus line 10)		24, 805, 745			0		11. 00
12. 00	TRANSFER TO/FROM AFFILIATES	15, 381, 027			0		0	
13.00		0			0		0	13.00
14.00		0			0		0	
15. 00 16. 00		0			0		0	15. 00 16. 00
17. 00					0		0	17. 00
18. 00	Total deductions (sum of lines 12-17)		15, 381, 027		J	0		18. 00
19. 00	Fund balance at end of period per balance		9, 424, 718			0		19. 00
	sheet (line 11 minus line 18)							
		Endowment Fund	PI ant	Fund				
		6.00	7. 00	8. 00				
1.00	Fund balances at beginning of period	0.00	7.00	0.00	0			1. 00
2.00	Net income (loss) (from Wkst. G-3, line 29)							2. 00
3.00	Total (sum of line 1 and line 2)	o			0			3. 00
4.00	RESTRICTED ACTIVITY		0					4. 00
5.00			0					5. 00
6.00			0					6. 00
7.00			0					7. 00
8. 00 9. 00			0					8. 00 9. 00
10.00	Total additions (sum of line 4-9)		ď		0			10.00
11. 00	Subtotal (line 3 plus line 10)				0			11. 00
12. 00	TRANSFER TO/FROM AFFILIATES		o					12. 00
13.00			o					13.00
14.00			0					14.00
15. 00			0					15. 00
16.00			0					16.00
17. 00	T + 1 + 1 + 1 + 1 + 1 + 1 + 1 + 1 + 1 +		0					17. 00
18. 00 19. 00	Total deductions (sum of lines 12-17) Fund balance at end of period per balance	0			0			18. 00 19. 00
19.00	sheet (line 11 minus line 18)				U			19.00
	10 (1 11 110. 10)	1	Į.	ı			ļ	

Health Financial Systems ST. JC STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES Provider CCN: 15-0010

				To 06/3	0/2018	Date/Time Pre 11/26/2018 12	
	Cost Center Description		Inpatient	Outpat	ient	Total	. оо р
	'		1.00	2. 0		3. 00	
	PART I - PATIENT REVENUES						
	General Inpatient Routine Services						
1.00	Hospi tal		32, 315, 30	8		32, 315, 308	
2.00	SUBPROVI DER - I PF						2. 00
3.00	SUBPROVI DER - I RF		5, 988, 75	0		5, 988, 750	3. 00
4.00	SUBPROVI DER						4. 00
5.00	Swing bed - SNF			0		0	5. 00
6. 00	Swing bed - NF			0		0	6. 00
7.00	SKILLED NURSING FACILITY						7. 00
8.00	NURSI NG FACILITY						8. 00
9.00	OTHER LONG TERM CARE		20 204 05	0		20 204 050	9.00
10. 00	Total general inpatient care services (sum of lines 1-9) Intensive Care Type Inpatient Hospital Services		38, 304, 05	8		38, 304, 058	10.00
11. 00	INTENSIVE CARE UNIT		7, 358, 63	1		7, 358, 631	11. 00
12. 00	CORONARY CARE UNIT		7, 550, 65	'		7, 330, 031	12. 00
13. 00	BURN INTENSIVE CARE UNIT						13. 00
14. 00	SURGICAL INTENSIVE CARE UNIT						14. 00
15. 00	OTHER SPECIAL CARE (SPECIFY)						15. 00
16. 00	Total intensive care type inpatient hospital services (sum of I	ines	7, 358, 63	1		7, 358, 631	16. 00
	11-15)		, ,			, ,	
17.00	Total inpatient routine care services (sum of lines 10 and 16)		45, 662, 68	9		45, 662, 689	17. 00
18. 00	Ancillary services		128, 934, 16	9	o	128, 934, 169	18. 00
19. 00	Outpati ent services			0 344, 2	275, 993	344, 275, 993	19. 00
20.00	RURAL HEALTH CLINIC			0	0	0	20. 00
21. 00	FEDERALLY QUALIFIED HEALTH CENTER			0	0	0	21. 00
22. 00	HOME HEALTH AGENCY						22. 00
23. 00	AMBULANCE SERVICES			0	0	0	23. 00
24. 00	CMHC						24. 00
25. 00	AMBULATORY SURGICAL CENTER (D. P.)						25. 00
26. 00	HOSPI CE				04.000	04.000	26. 00
27. 00	PHYSI CI AN REVENUE	\		0	94, 333		ı
28. 00	Total patient revenues (sum of lines 17-27)(transfer column 3 t	O WKST.	174, 596, 85	344, 3	370, 326	518, 967, 184	28. 00
	G-3, line 1) PART II - OPERATING EXPENSES						
29. 00	Operating expenses (per Wkst. A, column 3, line 200)			133 4	189, 959		29. 00
30. 00	ADD (SPECIFY)			0	107, 707		30.00
31. 00	(6. 26.1.1)			0			31. 00
32. 00				o			32. 00
33. 00				0			33. 00
34. 00				0			34.00
35.00				0			35. 00
36.00	Total additions (sum of lines 30-35)				o		36. 00
37.00	DEDUCT (SPECIFY)			0			37. 00
38. 00				0			38. 00
39. 00				0			39. 00
40. 00				0			40. 00
41. 00				0			41. 00
42.00	Total deductions (sum of lines 37-41)			400	0		42.00
43. 00	Total operating expenses (sum of lines 29 and 36 minus line 42)	(transfer		133, 4	189, 959		43. 00
	to Wkst. G-3, line 4)			1	l		I

		SEPH HOSPITAL & HEALTH CENTER		u of Form CMS-2	
STATE	MENT OF REVENUES AND EXPENSES	Provi der CCN: 15-0010	Peri od: From 07/01/2017	Worksheet G-3	
			To 06/30/2018	Date/Time Pre	pared:
				11/26/2018 12	:03 pm
				1. 00	
1.00	Total patient revenues (from Wkst. G-2, Part I,			518, 967, 184	
2.00	Less contractual allowances and discounts on pa	atients' accounts		365, 268, 888	
3. 00	Net patient revenues (line 1 minus line 2)			153, 698, 296	1
4.00	Less total operating expenses (from Wkst. G-2,			133, 489, 959	
5.00	Net income from service to patients (line 3 min	nus line 4)		20, 208, 337	5. 00
	OTHER I NCOME			_	
6. 00	Contributions, donations, bequests, etc			0	6. 00
7. 00	Income from investments			14, 000	1
8.00	Revenues from telephone and other miscellaneous	s communication services		0	
9.00	Revenue from television and radio service			0	
10. 00	Purchase di scounts			483, 923	
11. 00	Rebates and refunds of expenses			0	
12. 00	Parking Lot receipts			0	1
13.00	Revenue from Laundry and Linen service			0	1
14. 00	Revenue from meals sold to employees and guests	5		0	1
15. 00	Revenue from rental of living quarters			0	1
16. 00	Revenue from sale of medical and surgical suppl			0	16. 00
17. 00	Revenue from sale of drugs to other than patien			11, 219	
18. 00	Revenue from sale of medical records and abstra	acts		484	18. 00
19. 00	Tuition (fees, sale of textbooks, uniforms, etc	C.)		0	19. 00
20.00	Revenue from gifts, flowers, coffee shops, and	canteen		26, 083	20. 00
21. 00	Rental of vending machines			0	21. 00
22.00	Rental of hospital space			0	22. 00
23.00	Governmental appropriations			23, 325	23. 00
24.00	OTHER MISCELLANEOUS INCOME			461, 055	24. 00
24. 01	INVESTMENT INCOME			4, 975	24. 01
25.00	Total other income (sum of lines 6-24)			1, 025, 064	25. 00
26 00	Total (line 5 plus line 25)			21 222 401	26 00

21, 233, 401

1, 192, 884

682, 921 27. 01 1, 875, 805 28. 00

19, 357, 596 29. 00

26.00

27.00

26.00 Total (line 5 plus line 25)
27.00 IMPAIRMENT, RESTRUCTURING, NONRECURR

28.00 Total other expenses (sum of line 27 and subscripts)
29.00 Net income (or loss) for the period (line 26 minus line 28)

27. 01 BAD DEBT EXPENSE

CALCULATION OF CAPITAL PAYMENT		Provider CCN: 15-0010	Period: From 07/01/2017	Worksheet L Parts I-III	
			To 06/30/2018	Date/Time Pre 11/26/2018 12	
		Title XVIII	Hospi tal	PPS	
				1. 00	
	PART I - FULLY PROSPECTIVE METHOD				
	CAPITAL FEDERAL AMOUNT				
. 00	Capital DRG other than outlier			1, 197, 217	
. 01	Model 4 BPCI Capital DRG other than outlier			0	1.
. 00	Capital DRG outlier payments			12, 991	
01	Model 4 BPCI Capital DRG outlier payments			0	I
. 00	Total inpatient days divided by number of days in the cos	t reporting period (see insi	ructions)	47. 13	
. 00				0.00	
. 00 . 00	Indirect medical education percentage (see instructions)	the cum of lines 1 and 1 0	columns 1 and	0.00	
	Indirect medical education adjustment (multiply line 5 by the sum of lines 1 and 1.01, columns 1 and 1.01) (see instructions)				
00	Percentage of SSI recipient patient days to Medicare Part A patient days (Worksheet E, part A line 30) (see instructions)			3. 33	
00	Percentage of Medicaid patient days to total days (see instructions)			26. 24	
00				29. 57	9.
0. 00				6. 17 73, 868	
. 00					
. 00	Total prospective capital payments (see instructions)			1, 284, 076	12
				1. 00	
	PART II - PAYMENT UNDER REASONABLE COST				
00	Program inpatient routine capital cost (see instructions)			0	
00	Program inpatient ancillary capital cost (see instructions	s)		0	
00	Total inpatient program capital cost (line 1 plus line 2)			0	
00	Capital cost payment factor (see instructions)			0	
00	Total inpatient program capital cost (line 3 x line 4)			0	5
				1. 00	
00	PART III - COMPUTATION OF EXCEPTION PAYMENTS			0	1
00 00	Program inpatient capital costs (see instructions) Program inpatient capital costs for extraordinary circums	tancos (soo instructions)		0	
00	Net program inpatient capital costs for extraordinary circums [Net program inpatient capital costs (line 1 minus line 2)]			0	
30 30	Applicable exception percentage (see instructions)			0.00	-
00	Capital cost for comparison to payments (line 3 x line 4)			0.00	
00	Percentage adjustment for extraordinary circumstances (se			0.00	
00	Adjustment to capital minimum payment level for extraordin	,	(line 6)	0.00	
00	Capital minimum payment level (line 5 plus line 7)	riar y crrediiistances (Trne 2 7	CTITIC 0)	0	
00	Current year capital payments (from Part I, line 12, as a	pplicable)		0	
. 00	Current year comparison of capital minimum payment level		Less Line 9)	0	
. 00	Carryover of accumulated capital minimum payment level over Worksheet L. Part III, line 14)			0	
. 00	Net comparison of capital minimum payment level to capital	l payments (line 10 plus lin	ne 11)	0	12
. 00	Current year exception payment (if line 12 is positive, en			0	l '-
. 00	Carryover of accumulated capital minimum payment level over		,	Ö	
	(if line 12 is negative, enter the amount on this line)				'
. 00					1
5. 00	Current year allowable operating and capital payment (see	instructions)		0	15
				0	